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MICHIGAN MEDICINE

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THIS ISSUE SALUTES
WAYNE STATE UNIVERSITY
CENTENNIAL YEAR

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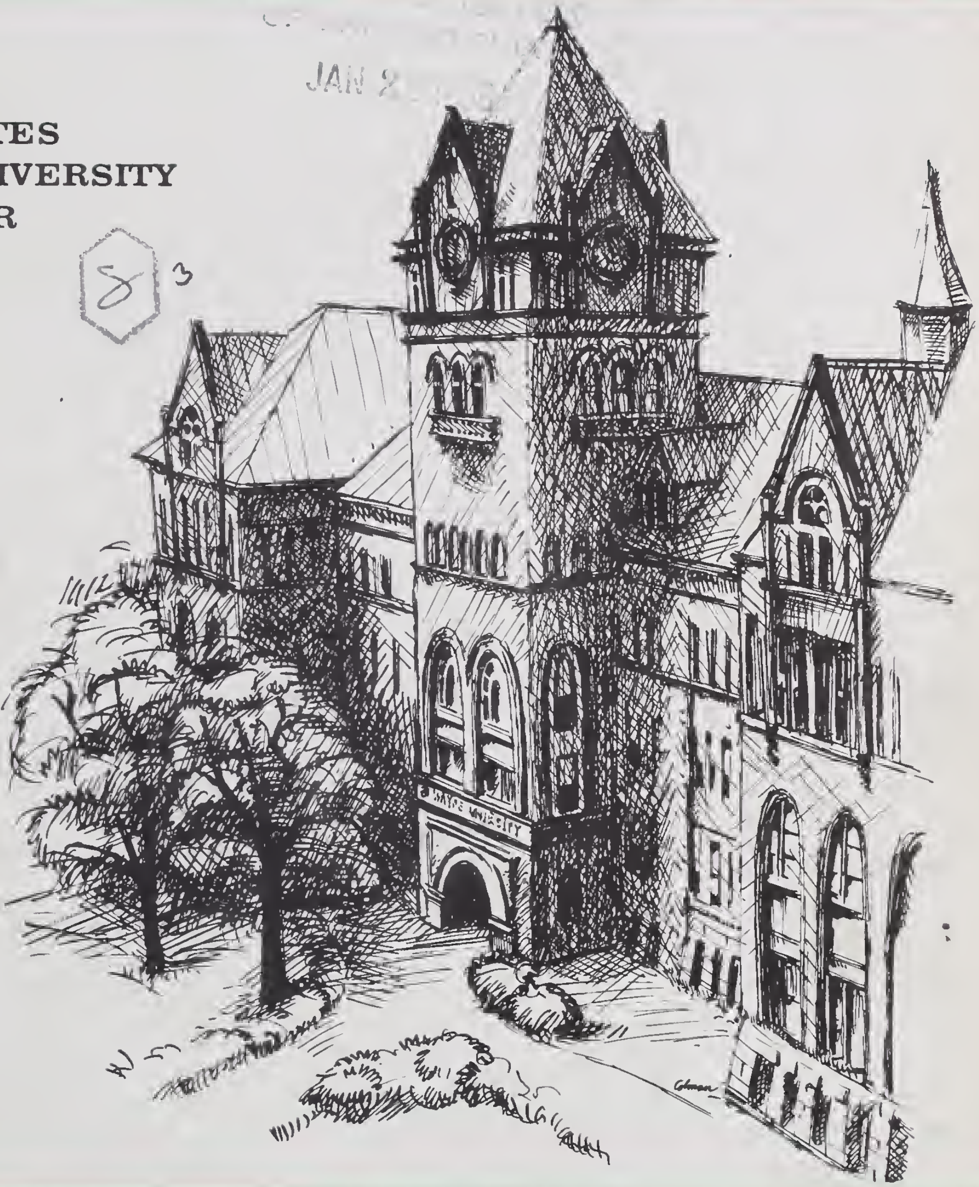
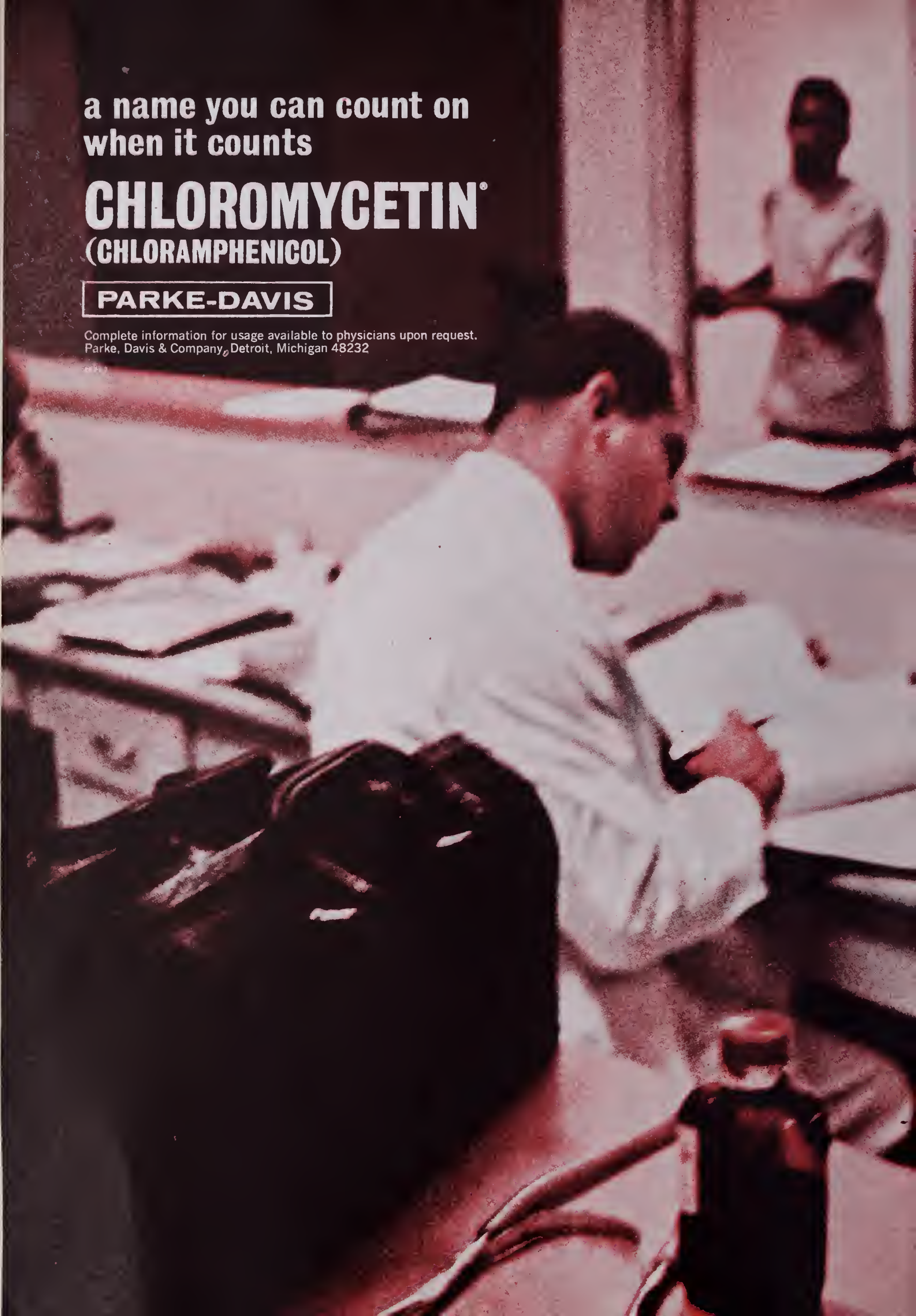


CHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 1 JANUARY 1968

EXCELLENT ARTICLES ABOUT WSU MEDICAL SCHOOL AND PROFESSORS
PROVOCATIVE VIEWPOINTS
MANY ARTICLES ABOUT UPCOMING MEETINGS
WHERE DOES MSMS STAND RE ETHICS, DISCIPLINE, STANDARDS?
AND MUCH MORE; ALL WITH A NEW 1968 LOOK



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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MICHIGAN MEDICINE

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ABOUT THE COVER

This issue is dedicated to Wayne State University Centennial, so appropriately the cover features a pen and ink sketch of Old Main. The sketch is by Joanne E. Colman, Detroit commercial artist; and is one of a series of sketches on note paper offered for sale by the WSU faculty wives.

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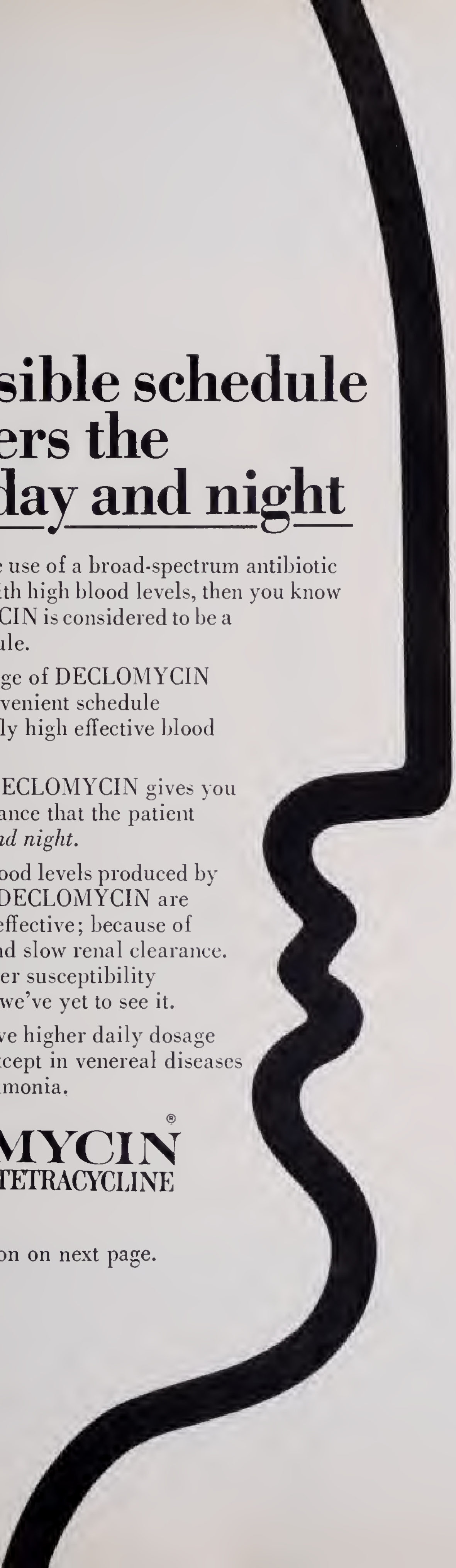
Prescribing information on next page.



b.i.d. The sensible schedule that covers the patient day and night

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

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Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Worthy of Comment

This issue of *Michigan Medicine* recognizes the Centennial of Wayne State University School of Medicine. We are proud of their achievements and excited by the projection they envision as they enter their Centennial Year.

The Michigan delegates at the Houston meeting of the AMA House of Delegates were proud to present a resolution extending "congratulations to Wayne State University and its School of Medicine for 100 years of devoted service to the people of the great State of Michigan."

* * *

At the risk of being repetitious I feel the urge to again emphasize the importance of involvement in your society. The 89th Congress has delved so broadly into the field of social welfare that the maze becomes literally incomprehensible even to its sponsors.

Our responsibility for implementation of the programs is awesome. We, the medical profession, must lead the local and state development of the services intended for the provision of more uniformly adequate availability of health services. This requires all of us to give time to a cooperative approach to each project as it develops.

Your state society is staffed to serve as a source for the coordination and research to aid in local programming.

Let me ask how involved you are with your society and its planning?

How actively are your society's committees engaging in your local problems and programs?

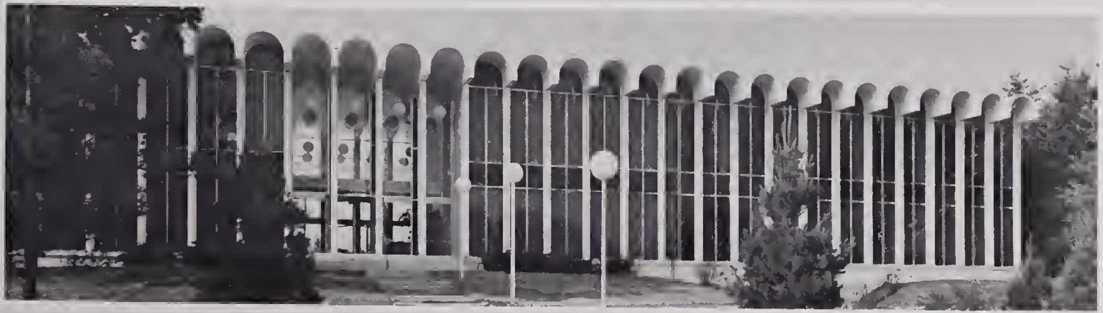
What assistance can our state society executive staff provide you?

* * *

I am sure too that you join me in applauding the "new look" of this January issue of our *Michigan Medicine*. Each year, the cover layout is changed to offer a fresh approach, and each year various changes are made throughout the official journal to improve content and to increase the readability.

Michigan Medicine truly is one of the best state medical journals in the nation as it seeks to provide good postgraduate scientific articles and vital news about MSMS and medicine in Michigan. The state journal has been praised by many for its broad scope of material in the socio-political-economic areas of concern.

Plaudits to The MSMS Council and its Publication Committee, with Brooker L. Masters, M.D., Fremont, Chairman; and also to Scientific Editor George H. Lowrey, M.D., and Managing Editor Herbert A. Auer.



MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Our Solemn Obligation

BY DONALD N. SWEENY, JR., M.D., CHAIRMAN, MSMS JUDICIAL COMMISSION

Should a Michigan physician lend the use of his name for testimonial advertisements?

Should a MSMS member allow his name — or the prestige of his professional status — to be used in the promotion of commercial enterprises?

These queries are typical of those asked of the Judicial Commission of the MSMS concerning the relationship of physicians to commercial advertising.

We now have some guidance from the Judicial Council of the AMA.

Irate complaints have come from doctors charging that those physicians who do lend their names to testimonials are "prostituting the profession." Some of the complaints stem from a rash of recent newspaper and magazine advertisements and also from book-jacket copy prepared by publishers of books written by physicians.

In rendering its recent opinion, the AMA Judicial Council considered only the advertisements in question. It did not assess the conduct of the physicians involved because (1) no charges had been brought against any physician as an individual and (2) the Council refused to impute improper motives to any of the physicians who, it felt, acted without any intent to violate ethical standards.

The AMA Council concluded, however, that it was imperative to warn physicians of the consequences of providing testimonials without fully considering their potential impact upon the profession.

Here is the opinion rendered by the AMA Judicial Council:

"It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

All of us are subject to forces more powerful than we can measure — the forces of public opinion. A sophisticated public stands by like an enormous conscience noting and commenting on our actions.

It is the solemn obligation of every physician to keep his profession from falling in public esteem. Each of us must help guide others so that not only his responsibility to the profession and to the public be fulfilled but also the standards of medicine be maintained at the highest.

Not the Only Ones . . .

BY ROBERT J. MASON, MD.,
CHAIRMAN, MSMS COUNCIL

The pilgrimage of many Detroiters this fall to the so-called "bare hand surgeon" in the Philippines, Tony Agpaoa, prompted me to reflect on the relation of faith to medicine and how we should, as a profession, react to situations like this.

This is a difficult one.

We should approach it with a good deal of reverence and caution. I would appreciate very much if you wrote me your reaction to my following comments and any additional thoughts which can help us develop guidelines in how to react to the "Tony Agpaoas."

* * *

We do not know all there is to know about medicine. We do know that the human spirit can be an important factor in recovery from disability and illness.

Many good doctors have received credit from their patients for successful treatment when a substantial factor in the recovery was the patient's faith in both his God and his doctor. It is right that this should be so. We call it "patient confidence" and it grows out of a feeling between the patient and the doctor that recovery is possible.

(In fact, the Medical Society has fought and will continue to fight against any organization, government or person that would disrupt this doctor-patient relationship for it is an integral part of good medicine.)

This does not discount medical science. There are surgical techniques, medicines and machines which can repair bodies, restore function, fight viruses and disease germs, etc. These too are necessary for recovery from most disabilities and illnesses.

It is adequate knowledge of these medical sciences and their relationship to the conditions and diseases of patients that the "Tony Agpaoas" lack. They will always lack these because they have not gone through the necessary schooling and research to find out what scientific aids are available, how they may affect the patient in their various usages, and how and when they should be used. Neither

Continued on Page 8

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

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timed-release tablet contains:

Triaminic®	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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have they developed the skills and judgments necessary to obtain maximal results from the application of medical and surgical knowledge.

With this lack existing on the part of the "Tony Agpaoas" the results of faith and hope alone cannot approximate the success of faith and hope on the part of the patient plus knowledge on the part of the duly trained and licensed doctor. In fact, without the latter, the patient is giving everything and getting less than he deserves in return.

Some "Tony Agpaoa" types prey on this blazing faith of wonderful people who want to get well. The damage these types cause lies in the delay in proper treatment occasioned by their ministrations and the discouragement that follows their failure.

The medical profession feels a responsibility to protect the sick from "quacks" who cruelly hoax the sick. Quackery *does* exist. Those who claim to do surgery in strange and secret ways are always unethical and usually quacks. That is why we of the Michigan State Medical Society in cooperation with state and federal authorities will hold a series of meetings around the state in 1968 to reveal the methods quacks use·

Insofar as the Agpaoa trip to the Philpipines is concerned, we would recommend against similar trips· Any gain in general health and well being arising from the Philippine sunshine and the spiritual uplift of cooperative effort may be some recompense for the time and money already spent, but we do not believe the travellers received medical treatment. It would seem that that is what most of them need and can obtain right here in Michigan."

The Cults

BY CARL O. RICE, M.D., EDITOR, MINNESOTA MEDICINE

A system for the cure of disease based on dogma set forth by its promulgator can scarcely qualify as an indispensable health service, nor should any recipient of government benevolence under Medicare be free to choose a system of therapy neither substantiated nor sanctioned by scientific medicine.

If we are to continue to operate a government for the benefit of the people, that government should feel obligated to protect us against health fallacies as well as against other forms of exploitation and chicanery. In the public interest do we not now have such agencies as the Interstate Commerce Commission, the Food and Drug Administration, the Federal Trade Commission, and others operating in their respective fields to protect us from abuses against which we could not individually defend ourselves?

The gamut of health cults runs from ingenuous faith healing to calculated fraud; there have been and may still be extant such "follies" as Autohemic Therapy, Poropathy, and Bio-Dynamo-Chromatic Diagnosis and Therapy, plus 1001 other pseudo-medical practices with no scientific validity. There are pathetically misguided persons who have profound but blind confidence in a copper wire bracelet or a "rheumatism ring" to prevent, alleviate, or cure arthritis; some fanatics ascend 150 steps or more on their knees to reach "miracle" altars or shrines for the cure of their ailments; other gullibles patronize the bonesetter, massager, the mesmerist, or the mere layer-on-of-hands; even the arcane rites of the voodooist or the necromancer can still attract a minority clientele.

Submitting oneself to any type of illegitimate therapy is the prerogative of the individual; but a government should not use tax revenue to support and thereby indirectly endorse such cults. Irrelevant to the issue is that fact that some legislatures may approve licensure of some of the cults.

It is significant that the cults which have been licensed by state legislatures, received the privilege to a limited practice many years ago when the gap between the abilities of the cultists and the medical knowledge of the day was not so wide nor so regrettable as current remarkable developments in scientific medicine have made it today.

It would seem that if many of our honorable United States senators are unwilling to commit themselves unequivocally on this important issue: namely, that of safeguarding their constituents' welfare in the medical field, we may have to become dubious of their sincerity and competence in other areas.

Are we to assume that they have not conscientiously informed themselves on this crucial matter, or that they have yielded to the pressures of wily lobbyists?

And this despite the fact that experts have advised them that medical cults have no sound scientific basis and should therefore be excluded from the health services eligible for government support!

This is no area for congressional compromise!

(Editor's Note: The above soliloquy by Editor Rice was printed with his permission and that of the Minnesota Medicine journal.)

A New Era Dawns For MDPAC

BY V. V. BASS, M.D., CHAIRMAN MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE

This could be the dawn of a new era in Michigan politics. There is a new respect for doctors

Continued on Page 15

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.

Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incide in patients receiving oral contrace tives: nausea, vomiting, gastroint tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, ede chloasma or melasma, breast chan (tenderness, enlargement and secretion), change in weight (incre or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when giv immediately postpartum, cholesta jaundice, migraine, rash (allergic), rise in blood pressure in susceptibl individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, preme struallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

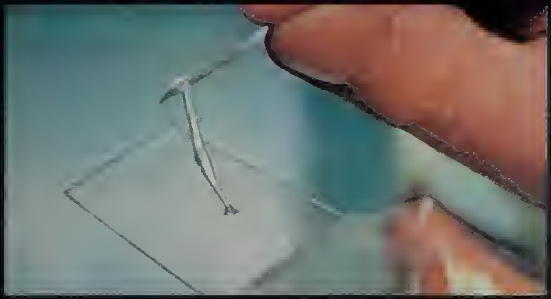
The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic functio tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

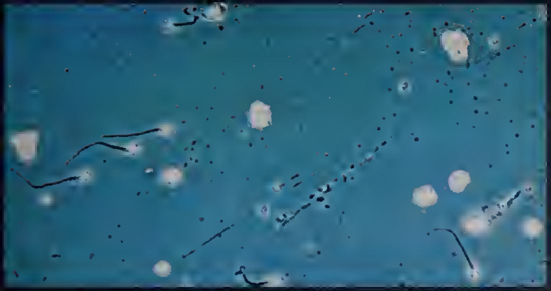
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

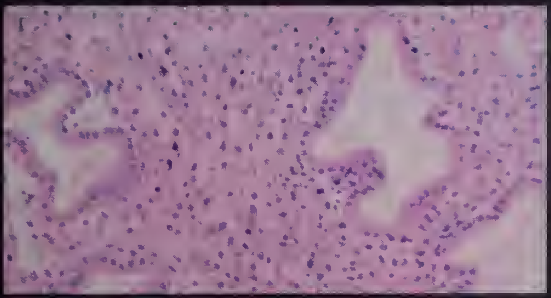
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

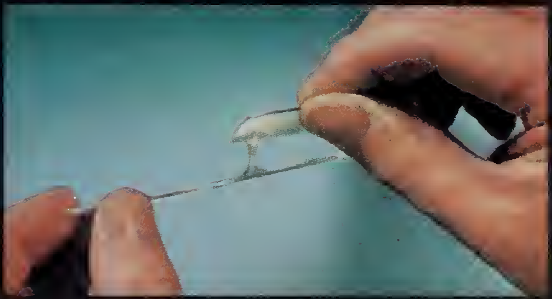


Spermatozoa appear healthy, active, freemoving.

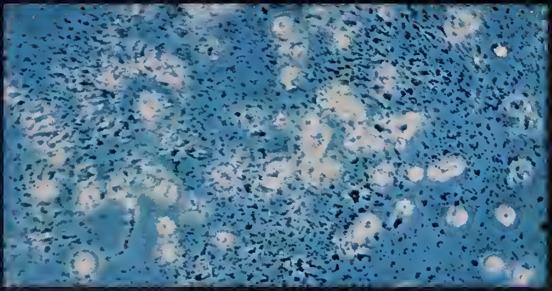


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

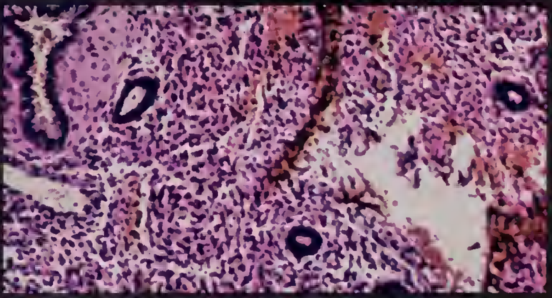
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

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An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

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Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

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fluocinolone acetonide

contraindicat precautions and side effects

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provides economy in two practical dosage forms

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Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream — 5, 15 and 60 Gm. tubes.

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of medicine who have welded together to form a statewide organization called MDPAC.

Nearly a hundred doctors and their wives hosted a score of legislators, party leaders and members of congress at a recent MDPAC-AMPAC workshop in Lansing.

Legislators from both major parties extolled both our past political effort and encouraged even greater participation of doctors and their wives during the 1968 and future election campaigns.

Doctor Donato F. Sarapo of Adrian chaired the event and merits credit for keeping the program informal and stimulating.

MDPAC was further advanced by action of the 1967 House of Delegates resolution which states: Resolved that, MSMS include the $25.00 donation to MDPAC and AMPAC in its billings, with a footnote that this portion is voluntary and not deductible on Federal income tax returns.

MDPAC can be likened to David of biblical note in his battle with Goliath. Since with a small amount of money, a moral cause (good government) Goliath or the Committee on Political Education of the AFL-CIO and the Chairman of the State Democratic Central Committee, Mr. Zolton Ferency would not have singled out MDPAC in his recent tirade on political funds. Let us remind Mr. Ferency MDPAC doesn't consider party but good candidates for good government.

We are a fund raising organization and supply seed money to campaign committees of responsible candidates.

MDPAC is being noticed by the professionals. We also are becoming more sophisticated in our political activity. Doctors, their wives, and friends from all over the state, are concerned about people, government et al. Our concern is being felt.

Thanks again Mr. Ferency for your recognition.

Join the Team Now

BY BROCK E. BRUSH, MD, CHAIRMAN MSMS COMMITTEE ON PUBLIC RELATIONS

Every day every member of MSMS is responsible for the success or failure of the MSMS public relations efforts.

While every member may not realize it, he is unofficially a member of the MSMS Committee on Public Relations. Every day, every doctor must help solve our complex problems . . . some people are not convinced that health care is available day and night . . . some occasionally may have to wait in a doctor's office . . . some do not believe physicians are interested in the elderly . . . some wish they had closer patient-physician relationships . . . etc.

The projects of the Public Relations Committee are developed and refined from the resolutions adopted by the House of Delegates, from action motions of The Council, from recommendations of the many MSMS committees and from ideas expressed by members.

I would also like to stress the value of AMA Public Relations seminars and meetings. We are able to learn of the programs and techniques used in other states and to exchange ideas on the worthwhileness of a particular effort.

The Public Relations Committee seeks to outline programs in broad general guidelines for the staff to implement by working with MSMS officers, committees, delegates, members, auxiliary members, medical assistants, the news media, schools· etc.

As Chairman I want to recognize the excellent working relationship between the MSMS staff and the PR Committee. The staff continues to suggest workable, unique programs to meet our public relations needs. The staff then takes the broad guidelines approved by the Committee and The Council and carries them out with imagination and dedication.

If we are to combat the accusations that M.D.s are responsible for rising medical costs, for drug costs, and for problems that really are hospital based, we must have total effort of all the M.D.'s as well as the PR Committee and the staff. It is getting to be a bigger and bigger job to keep the record straight.

Ideally every MSMS member should accept the challenge, opportunity and responsibility to serve on the big, every-member Public Relations task force and submit ideas and volunteer for various assignments.

Why Read Journals?

Why do doctors read their state medical society journal?

That question recently was answered by C. Joseph Stetler, President, Pharmaceutical Manufacturers Association, in his address to the Annual Conference of Journal Editors. Mr. Stetler said:

"In the mounting barrage of medical communication hitting the doctor from all sides, the state journal remains notable for its ability to cover the local scene. It provides the doctor with medical articles of special interest in his own area. Usually they are practical articles for the busy physician with new developments being discussed against the background of local conditions. The state journal performs a proper function in reporting on the activities and accomplishments of doctors within the state which no national publication could possibly cover.

"These are important considerations. They give the publications a built-in advantage which makes them uniquely attractive to their readers, and hence enhances their value as a vehicle for conveying an advertising message."

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The Urban University And the Urban Medical School

BY WM. R. KEAST, Ph.D., PRESIDENT,
WAYNE STATE UNIVERSITY
DETROIT

I am pleased to have the opportunity in this issue of *Michigan Medicine* to discuss the responsibilities of Wayne State University in modern society and to focus on the role of our School of Medicine in meeting these responsibilities.

The University began 100 years ago as a small medical college in a post-Civil War city with a need for trained doctors. Today it is a huge urban institution which provides educational services for more than 57,000 people, including 31,000 students seeking degrees and 26,000 in urban extension courses.

> *It is particularly appropriate that during its Centennial Year the University is developing the theme "The Urban University and Urban Society."*

The question to which we are addressing ourselves this year is a special case of an old question concerning the relationship between the University and society. In my opinion, this relationship involves problems that are among the most crucial facing our society and which, if they are not solved, may destroy our society.

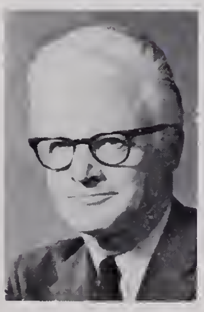
UNIVERSITIES MUST PROVIDE the intellectual and moral leadership on which the reconstruction of our cities and hence of American life generally must depend.

The University's engagement with urban problems should satisfy the conditions of university inquiry into any problem whatsoever. These conditions are the obligation to make explicit the principles, value judgments, assumptions, and objectives underlying the inquiry, and the necessity to develop a plurality of approaches and methods of analysis. In so doing, and in encouraging the largest number of various ways of attacking problems, the University will have to find the resources to carry out new social responsibilities on a continuing and not merely on an *ad hoc* basis. It will have to develop an institutional base large enough to take on these responsibilities without prejudice to the other and more traditional obligations and activities of the institution.

IT IS PARTICULARLY appropriate, in considering the theme of our Centennial Year, to consider the vital role of the School of Medicine. Since the end of World War II, all medical schools, especially those in urban settings, have been faced with medical, social, economic, and political developments of extraordinary and unforseen complexity. These include major population increases and changes in patterns of population, changes in patterns of disease, scientific advances at an almost exponential rate, increasing demands for improved delivery of increasingly expensive health care, and rapidly developing governmental involvement in medical education, research, and care. One result is that there are shortages of people in every health professional and technical field.

Many medical schools are expanding and new ones are being planned and started. Nearly all medical schools have been making detailed reviews of the objectives, functions, and curricula.

> *The School of Medicine of Wayne State University has likewise been engaged in a*



AUTHOR

Wm. R. Keast, Ph.D., President
Wayne State University

The present Medical School building at Wayne State University was completed in 1954. At the same time medical classes no longer met at the old building at St. Antoine and Mullet streets. Other WSU photos appear on pages 23, 34, 38, 43, 118.

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major self-study which has resulted in the presentation to the University of a detailed analysis of needs and objectives for the next 10 years.

Since 1945, the School of Medicine has grown more than any other medical school in the United States. The University is committed to an increase in the entering class from 125 to 208 in 1970. In collaboration with private and public institutions it is engaged in the development of a complex medical center which will be of vital importance to the community and the State.

THE FACULTY OF THE School of Medicine has paid particular attention to the following major programs and responsibilities:

1) A program of medical education encompassing the lifetime of a physician, with increasing emphasis on the social, cultural, economic, and political effects upon health and disease and the delivery of health care services.

2) Increasing collaboration with other schools and colleges of the university, because the problems of health involve more than medicine.

3) The development and expansion of strong graduate academic programs as a source of faculty and research strength.

4) Participation in the expansion of educational programs in the allied health sciences.

Urban community health is an inextricable part of the urban difficulties that threaten our society. If they cannot be solved in Michigan, they cannot be solved anywhere. Wayne State University has a vital role in seeking and developing solutions. With its School of Medicine, it is prepared to meet its local, state, and national responsibilities.

Introducing . . .

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Vice President for Medical School Development

ERNEST GARDNER, M.D.
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School of Medicine

On WSU Board . . .

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A. H. SOKOLOWSKI, M.D.

ALFRED H. WHITTAKER, M.D.

Myocardial Infarction - Basic Clinical And Therapeutic Considerations

BY RICHARD J. BING, M.D.
GLEN H. DOUGLASS, M.D.
BOTH OF DETROIT

The current population of the United States as well as that of any other civilized country is menaced by an epidemic of coronary artery disease. Statistical analyses have shown a tremendous increase in frequency of this disease over the last year.[1] This increase is certainly real, and is not due to better recognition by the physician.

Although Herrick described coronary occlusion and myocardial infarction only several decades ago, there is no question that in the last 20 years, the disease has become more common amongst all members of the civilized community. It is evident from the Tecumsch and the Framingham studies that there exists a coronary profile which makes it possible to predict the susceptibility of an individual to the disorder.[2, 3]

IT IS THE PURPOSE of this discussion to discribe briefly some of the basic investigative, clinical and therapeutic work currently undertaken with particular emphasis to this work carried out in this Department of Medicine. This report does not pretend to represent a review of this extensive subject.

Basic Research

The diagnosis of myocardial infarction has profited greatly from basic research. For example, enzyme tests for the diagnosis of myocardial infarction owe their discovery to research in biochemistry.[4] Basic research in coronary artery disease is, in its broadest aspects, both epidemiological and biochemical.

Epidemiological studies have been carried out in many countries and at many centers, and the conclusions reached are that myocardial infarction and coronary artery disease are diseases of civilization and must be related to diet and to the way of living.[5, 6] This epidemiological work is closely related to studies on lipid metabolism and the mechanisms which are responsible for the accumulation of cholesterol and other lipids in the arterial wall.

Despite much research in this field, no definite conclusions have been reached. We still are not certain whether the lipids are synthesized in the vascular wall or whether they reach the vascular wall from the blood."

Isotope studies have suggested that the arterial wall is able to synthesize especially phospholipids.[8] Much basic research in coronary artery disease is related to lipid metabolism, a complex and complicated field which has grown into a separate specialty of Internal Medicine and Biochemistry.[9]

OUR MAIN INTEREST in this department has centered on the biochemical changes that occur in experimentally produced myocardial infarction. This work, carried out by Gudbjarnason has indicated that the early changes occurring after experimentally produced myocardial infarction consist of a rapid activation of a biochemical pathway, the pentose-monophosphate shunt.[10]

The importance of this finding is threefold: First, the pentose-monophosphate shunt furnishes triphosphopyridine nucleotide (TPN) which is essential for the formation of triglycerides, which then are deposited in the infarcted area. Secondly, this pathway furnishes energy for regeneration of the muscle. Thirdly, one is in a position, by studying the activity of enzymes connected with this shunt to follow the biochemical history of the healing of an experimentally produced myocardial infarct. This can be done by measuring the activity of enzymes connected with this biochemical pathway, such as glucose-6-phosphate dehydrogenase.

The studies illustrate that the activity of the hexosemonophosphate shunt can be increased by certain substances such as anabolic steroids, by ascorbic acid, and by insulin and growth hormone.[11] The practical application of these findings awaits further studies.

ANOTHER BIOCHEMICAL approach to the problem of myocardial infarction consists in determining protein synthesis in the infarcted heart. It could be shown that immediately following myocardial infarction, protein synthesis in the area of infarction declines; soon however a marked increase in the activity in the protein synthesis as well as in the formation of nuclecoproteins occurs.[12] This study has been accomplished by following the rate of incorporation of a labeled amino acid (glycine 2-C_{14}) which the tissue incorporates into protein. Of interest are the studies which have shown that these processes commence in the cell nucleus.[12]

> *Another sideline of this study has been the experimental finding by Braasch and Gudbjarnason that cardiac hypertrophy can result from myocardial ischemia.*[13]

This has been demonstrated in animals in which ameroid rings were placed around the three coronary arteries. These rings, first developed by Vineberg, are small steel rings with an inner layer of casein.[14] As the casein absorbs fluid, it swells, slowly occluding the vessel. It has been shown in this laboratory that when occlusion of the coronary vessel occurs rapidly (within a week), hypertrophy of the heart muscle ensues. This is an observation which may have its clinical counterpart in the cardiac hypertrophy not infrequently observed in patients with coronary artery disease.[15, 16]

It is questionable whether this hypertrophy is the result of anoxia or some other factors as yet not understood. The bridge between these experimental observations and their clinical application has yet to be built.

Recognition of Coronary Artery Disease

The recognition of coronary artery disease has been primarily based on clincial findings and on electrocardiographic evidence. An accurate history is still most important in the recognition of arteriosclerotic heart disease. However, as all clinicians know, there are other factors which can produce chest pain and the separation of these factors from myocardial ischemia is not easy, particularly since the electrocardiographic evidence even under stress conditions (exercise) is not always reliable.[17]

> *For this reason, this laboratory has for the last 12 years worked on other methods which may be helpful in the recognition of coronary artery disease. One of these has been based on the determination of myocardial blood flow, before and after nitroglycerin.*[18]

It has been known since the 19th century that nitroglycerin relieves anginal pain. The drug is still a most effective agent. However, the mechanisms of its action were not clear. It has now been shown in this as well as other centers, that nitroglycerin acts on the peripheral vascular bed and relieves angina pectoris primarily by diminishing the demands of the heart for oxygen through diminished inflow of blood to the heart.[19]

However, this may not be the only mechanism of the action of nitroglycerin. Recently, Ogawa and his co-workers in this laboratory have shown that nitroglycerin and related compounds are monoamine oxidase inhibitors.[20] This has been demonstrated both in vivo and in vitro experiments.

It has been known for a number of years that amine oxidase inhibitors may be useful in the treatment of angina pectoris, although the clinical application of these drugs is not practical.

What clinical significance, if any, these data have remains to be seen.

IT WAS MENTIONED in a previous paragraph that the effect of nitroglycerin can now be explained primarily by its peripheral action. Most investigators agree that although nitroglycerin increases the coronary blood flow in normal individuals, it does not do so in patients with arteriosclerotic heart disease. This has been confirmed in

BING

CO-AUTHORS

Doctor Bing is Professor and Chairman, Department of Medicine, Wayne State University School of Medicine, Detroit, Michigan, and Doctor Douglass is Chief Resident in Medicine, Wayne State University School of Medicine and Detroit General Hospital.

Their work is supported by U.S. Public Health Service Grant No. HE-05043 and The John A. Hartford Foundation.

DOUGLASS

this laboratory, using a newly devised method based on the use of a positron emitter, Rubidium 84.[18, 21] This isotope decays by emission of positive charged electrons (positrons). Each positron annihilates with an electron in the body, producing two gammaphotons, directed 180 degrees apart. When these gammaphotons strike a coincidence pair of detectors simultaneously, a count occurs. The method possesses certain advantages. One of these is that the radioactivity of the heart can be readily separated from that of other structures, making complicated collimation unnecessary.[21] A specially designed apparatus is necessary, the design of which is based on the coincidence principle. By recording activity over the right side of the chest, the positron emissions from the heart alone can be determined separately.

> *In the beginning we used a method in which Rudidium 84 is infused continuously for periods of eight minutes each and the emission from the heart measured over this period. This steady state method has certain disadvantages i.e., rapid changes in coronary flow cannot be assessed, and the method necessitates a computer for calculating the results.*

For this reason we are now beginning to use a method in which a single slug or bolus of Rubidium is injected intravenously into the patient; from the myocardial uptake and the activity in arterial blood, the coronary blood flow can then be calculated.[22, 23] This method is technically simpler and does not necessitate computer calculations. Using both these methods it has been shown that nitroglycerin causes an increase in myocardial flow in normal individuals but not in patients with arteriosclerotic heart disease. For this reason the method may conceivably become a valuable adjunct in the presumptive diagnosis of coronary artery disease.[18]

OTHER METHODS FOR recognition of coronary heart disease, used in various clinics, are based on modifications of the Master two-step test. For example, exercise can be graded not by the number of steps a patient takes during the test but by changes in heart rate.[24, 25] Selective coronary arteriography has become the most important advance in the localization of arteriosclerotic changes in the coronaries.[26] The method is invaluable prior to subjecting a patient to surgery for intractable angina pectoris. The fact remains that the method should be used only if the question of operation arises or if the diagnosis of coronary artery disease must be excluded for important reasons.

Some Aspects of Treatment Of Coronary Artery Disease

The value of an operation, devised originally by Vineberg, is designed to alleviate intractable angina pectoris; this procedure has been quantitatively evaluated in this laboratory.[27] The operation consists in the implanation of one or two mammary arteries or arterial grafts into the myocardium. Tschopp and Braasch in this department have evaluated the vascular changes which occur in the hearts of animals subjected to this procedure. They have produced coronary insufficiency by ameroid rings (see above).[27] Following this they have implanted the internal mammary artery into the ischemic myocardium and have measured the vascular capacity as well as the capillary flow in the heart muscle of these animals. The results have indicated that the Vineberg operation produces an increase in coronary capillary flow, preceded by an augmentation in coronary vascular capacity. Whether these results are applicable to man is, of course, not clear but they are certainly encouraging.

> *A definite advance in the treatment of myocardial infarction during the last years has come from the treatment of Coronary Care Units.[28, 29] The construction and maintenance of such units has become an essential part of hospital planning.*

Close supervision of coronary patients is necessary since it has been shown that most of the deaths due to myocardial infarction occur within the first 24 to 48 hours, and that these deaths are due to cardiac arrhythmia, shock and cardiac arrest.[30, 31] Unfortunately, the treatment of cardiogenic shock has been disappointing and cardiogenic shock remains a most serious problem.

It is possible that in the future the construction of artificial heart and myocardial by-pass procedures will furnish a better way for the treatment of cardiogenic shock. Even the excision of necrotic muscle has been attempted with some success. However, shock remains a most serious complication which has so far resisted effective treatment. The treatment of arrhythmias with the

D.C. Defibrillator has resulted in marked diminution in mortality and pacing of the arrested heart has become a relatively simple procedure.[32, 33]

One of the most important features of a Coronary Care Unit is the role of the nursing staff. Physicians are not always immediately available for these emergencies and trained nurses must often perform these emergency tasks.

Prevention of Coronary Artery Disease

This aspect furnishes the best hope for the future.[34] Of particular importance here is a consideration of the coronary profile as was mentioned in a preceeding paragraph.[35] It has been shown that the presence of two of the so-called risk factors predispose a patient to coronary artery disease and possible myocardial infarction. Some of these risk factors are diabetes, hypertension, elevated cholesterol, and genetic factors. The use of compounds (Atromid-S) which lower blood lipids is promising, but as yet clinically unproven.[36]

The relation of mental tension to coronary artery disease has never been reliably established. Hypercholesterolemia certainly is of great importance and so are hypertension and genetic factors. Diabetes plays a predominant role as a risk factor.

How is one to prevent the occurence of myocardial infarction in these coronary prone individuals? A combination of the right amount of exercise with the right amount of diet is important.

An interesting experiment has been carried out in New York. There a Coronary Club has been formed.[37] The members of this club voluntarily subscribe to a diet which is low in saturated fatty acids, and which consists to a large extent of fish and poultry with a marked reduction in the intake of animal fat including beef and hard cheeses. The incidence of coronary artery disease in this group was considerably lower than in the general population.

The Public Health Service has embarked on a very extensive program for the study of myocardial infarction. Wisely, the service is using funds separate from those earmarked for individual research grants. However, we fail to share the pessimisms expressed by some concerning our knowledge of coronary artery disease. It has been said for example, that "A systematic review of our understanding of myocardial infarction and its management produces a startling picture of ignorance".[38]

WE BELIEVE, IN CONTRAST, that a great deal has already been accomplished all over the world and that it is through individual research that most scientific problems will eventually be solved.

Individual initiative and individual efforts will always remain the cornerstone of scientific success and no amount of planned coordination will ever replace them.

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The Detroit College of Medicine is remembered by many graduates. Erected in 1889 at St. Antoine and Mullet streets, it was in use for more than 50 years until it was replaced in 1954 by the present tall building.

The Medical School Deanship: Facts and Fancies*

BY MORTON LEVITT, Ph.D.
DETROIT

> *Those who have experience in such matters are aware that, in most cases, the defective constitution of German orchestras and the faults of their performances are due to the shortcomings of the conductors (Capellmeister," "Musikdirectoren," etc.) The demands upon the orchestras have increased greatly of late, their task has become more difficult and more complicated; yet the directors of our art-institutions display increasing negligence in their choice of conductors.*[1]
>
> —*Richard Wagner*

In a book which excited considerable controversy in the music world almost 100 years ago, Richard Wagner defined the role of the conductor of an orchestra as simply "to give the *beat* to the band." He made it quite clear that no conductor was qualified to tamper with the composer's work; his job was to keep the orchestra marching in time.

The parallel with the traditional role of the dean in medical education is quite obvious. If we take the World War II period as our water-shed, we find that there were some 77 medical schools in existence in 1941. A number were still proprietary, i.e., they were entirely independent of university affiliation. The total number of medical students enrolled was 22,000, and the graduating class that year was just over 5,000.

ONLY A HANDFUL of schools had anything resembling medical centers; most of the teaching was done in hospitals with whom there was only the most casual legal affiliation; almost all of the teaching was done by private practitioners who served on a voluntary basis; there was only the most superficial interest in and support for research; and today's familiar "three-legged stool" (teaching, research, and service) was largely visible in its patient care aspects. Medical school budgets were small, and administrative relationships with the faculty were casual. The dean did the admitting and excluding of students, often aided by a good secretary; performed the expected ceremonials, and frequently ran a major department of the school or a large private practice as well. In a variety of ways, he admirably filled Wagner's prescription for the conductor of the orchestra.

Without attempting to make any suggestions that things have changed for the better, things have indeed *changed* since the end of World War II.

There are 94 medical schools in operation today, but of the approximately 20 new institutions, only one existing apart from a university has been approved (and even this one has a technical association with an omnibus-type city university), and there is a strong determination on the part of accrediting agencies to see that this number does not increase. There are approximately 33,000 students currently in attendance, and the graduating class next spring is expected to be just under 8,000.

Better than half of the schools today exist in conjunction with an identifiable medical center, and few indeed are the schools that can afford "informal" agreement with affiliated hospitals.

MOREOVER, THE VOLUNTARY teaching base is pretty much a thing of the past. While private practitioners continue to make significant auxiliary contributions to clinical programs, the control of departments has almost entirely passed into the hands of men employed by the school on a full-time basis. A recent study by the AAMC disclosed that American medical schools in 1966 were staffed by some 15,000 full-time faculty members.

Moreover, from the tip of the tail of the dog, research threatens to become the whole dog itself; almost $370,000,000 was spent last year on program support from Federal, State and private sources, and each year sees a substantial increase in over-all support.

Medical school budgets have increased algebraically and consume inordinately large portions of university expenditures. Administrative-faculty relations have become institutionalized with advisory executive committees and faculty senates the general rule; and while appointment of departmental chairmen is still regarded as an executive prerogative, faculty usually serve on selection committees for such positions, and the dean only rarely is asked to meet and/or approve the routine faculty appointments below the chairman level.

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* There are three possible definitions for the term "fancy." Used as a noun (fancier), the *New Century Dictionary* (1959) states "one who imagines, or people who in their speculations . . . are not reasoners but fanciers." On the other hand, *A Dictionary of Slang and Unconventional English* (1961) defines the verb form "fancy" as "to have too high an opinion of oneself, of another, of a thing." Among alternative definitions, this last source offers "a kept woman" and "a warship notable for smartness, but generally very uncomfortable to live in." Here as elsewhere in this land of the free, the reader is invited to "pay his money and make his choice."

TODAY'S DEAN IS not likely to have much to say about admissions or promotions of students, and despite the invariable protestations to the contrary, he also hardly ever retains any real scientific or clinical responsibility. Like his confrere of the past, he still manages the ceremonials of the office. Sad to say, this may be the major context of student contact with him; he greets them formally on Orientation Day, addresses them in a body on a few specified occasions each year, and confers the degree when graduation requirements are completed.

The impersonal nature of his relations with students is hardly a matter of choice, for most deans come to their high position with impeccable credentials in student relations. They have either been chairmen of major departments, or unusually gifted teachers, or as is often the case, served as sub-deans with large responsibility for student affairs. It is therefore hardly lack of interest which keeps the dean from his student charges. It is rather the "big business" nature of his over-all responsibilities which ultimately requires that he delegate more and more tasks to others. Unlike presidents of large corporations, he is relatively poorly paid. Salaries range from $25,000 to $40,000 annually, with the bulk falling into the $30,000 to $35,000 class. This is usually what a young surgical or medical resident anticipates making the second or third year after completion of training.

LIKE LEADERS IN the business, but unlike his academic counterparts in other professional schools, the medical school administrator has shaky tenure. In 1965, "48% of deans had served for less than four years and only 27% had served for more than eight years."[2] The average length of tenure is apt to be something around six years, and since 77% of recent deanship appointments were made from within the school, it can be expected that most of the ex-deans return to academic life at the same institution.

> *Deans come primarily from the clinical branches of medicine these days, although there is a fair sprinkling of basic scientists, usually from anatomy or chemistry, in the group.*

Within the clinical group, internists and surgeons are in the majority, although recently the University of California chose an anesthesiologist, making a kind of "first." There has also been a spate of pediatricians and psychiatrists in recent years who have accepted decanal posts, leading to a rash of probably apocryphal explanations about the faculty being "childlike" or "needing psychotherapy but having tenure."

There is no easy method of identifying a dean's responsibilities by the generic title. Of the 90 some schools currently in existence, 71 have a senior executive officer simply entitled "dean." Fifteen other schools have a man at the controls who also has major university responsibility as well. This relates in the main either to the health sciences (a general category involving medicine, nursing,

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dentistry, or public health), or to the medical center. This hard pressed group can be readily identified by their titles. They are commonly "Vice-President in charge of ————, and Dean of the School of Medicine."

A few of these managed during their career to give up the deanship while retaining the Vice-Presidency of the university, and they numbered 27 in all in 1966-67.

By far the largest new growth is the category of associate and assistant deans. Almost 260 individuals are so identified in the latest roster of the AAMC, and the number is almost equally split between the two ranks.

Their professional origin is far more variegated than their superiors (one has no formal academic degree, a few have business or government backgrounds, a number are behavioral scientists, but most come once again from the major clinical disciplines), and their responsibilities can be subsumed under a relatively brief list of categories — admissions and student affairs, academic affairs, clinical coordination, postgraduate education, and business affairs.

Irrespective of the number of assistants or superiors, the dean is clearly the "man in the catbird seat." He must represent the university to the medical faculty, the medical faculty to the university, each to the public, and must at the same time operate a business establishment with a total budget which may exceed $35,000,000 annually, and with a capital plant which quite conceivably could be valued at three or four times that amount at replacement cost. He may be responsible for the teaching and research function of up to 4,000 hospital beds in a number of hospitals in a large medical center, be required to set policies for out-patient clinics which treat 400,000 patients annually, and be asked to define the objectives for an educational program which embraces almost 1,000 medical students, 450 graduate students, 500 to 600 interns, residents and fellows, and perhaps 1,500 graduate physicians annually in continuation courses. The above figures admittedly represent the outer reaches. It is unlikely that any one school is accurately pictured in all essentials, but the figures are relatively close for the larger institutions in our land.

The drive for the expansion of class size requires ever greater expenditures of time for planning for new facilities, faculty recruitment, and curriculum revision. Medical center direction demands intimate knowledge of real estate operations, of condemnation proceedings, of modern hospital planning, construction, and financing, of the finite details of present day patient care, and finally of the changing patterns of payment for health care.

The acceptance of research grants by the school usually makes the dean the responsible financial and scientific officer. It is likely that he has been required to sign as consentor to the scientific validity of the original application, and he is certainly held responsible for the financial and ethical conduct (involving humans and animals) of the research. His stewardship is subject to Federal audit, and because of the vast number of developing federal programs involving research, education, and patient care, the dean must not only be *au courant* with grant programs as they develop; he must, in effect, keep well ahead by maintaining sound governmental liaison in order to either support or oppose pending programs.

At the same time, he must be at work formulating plans to implement "passed but not yet funded" legislation. In the words of Dean John E. Deitrick of Cornell University Medical College:

"The schools receive funds from so many agencies and divisions of government and in such amounts that administrative and accounting procedures as presently organized are creaking and are on the verge of breaking down. The National Institutes of Health have found it necessary to hold regional meetings with deans and business officers to explain policies and clarify regulations and acceptable accounting procedures. To many of us, it seemed vital — and I'd like to emphasize this — vital to the future welfare of the medical colleges that we make every effort to develop methods for the intelligent direction of and accounting for these funds if we are to maintain the public confidence in our institutions."[3]

To summarize briefly the above *bouillabaisse*, the life of today's dean is complicated by a variety of factors. Prime among them and in unranked order are:

(1) the immense growth in size of the general operation of medical schools,

(2) the changing nature of community demands upon the medical school,

(3) the expansion of service requirements with

attendant increase in planning, staff, and plants,

(4) the financial complexity of medical school operations,

(5) the development of special programs with consequent highly specialized responsibilities, and

(6) the changing nature of medical education in both its undergraduate as well as its graduate segments.

James Miller has described something called an "information glut" and concluded that "there is a maximum channel capacity for living systems at various levels."[4] One of the most experienced ex-deans, Vernon W. Lippard of Yale, puts the matter more conversationally in the statement quoted below:

"I have tried to think what the forces are that have interrupted the complacency of the deans and departmental chairmen, or have at least made us conscious of the fact that we are not organized to deal with our administrative problems as effectively as we were 20 years ago . . . I can remember the day when you could formulate a budget some months in advance of the fiscal year and know where you stood. There was never enough money, but you adjusted to your poverty and did your best with the staff and equipment you could afford. Now, sources of funds in the form of research and training grants appear and disappear at odd moments, personnel come and go, and you never know where you stand until some time after the end of the year. Each faculty member is responsible for financing not only his own research but that of a group of postdoctoral fellows and research assistants working with him, and continual vigilance is required by the department chairman to keep the empire builder from building a larger empire than he can properly supervise or accommodate. To this is added new complexities in the financial relationships with our affiliated hospitals. The rule of thumb that universities are responsible for teaching and research and that hospitals are responsible for service used to serve as a basis for determining most of these relationships, but now we have clinical research centers, for example, which must be combined operations."[5]

This article is certainly not meant to be either a plea for "more understanding for the 'poor' dean," or a request for a different set of ground rules for the position. It is rather to be viewed as an effort to set out in all its chaotic ramifications the multiple requirements of the major executive office in the medical school.

The statistics cited earlier do suggest that some deans grow rapidly disenchanted and return to greener pastures. While these may finally be viewed as the wisest of the breed, others (more masochistic, perhaps?) do persevere and attempt to stay abreast of the tide.

THE REAL PROBLEM is that there has literally been a major revolution taking place in medical education over the last 25 years. Other than course titles, and even here there are many innovations, and departmental designations, all else in schools of medicine has apparently changed. This is, of course, in the nature of things, and no serious observer would protest this state of affairs. What is a matter of great concern, however, is the *rate* and *nature* of the change. The changes have come on with such rapidity that they often appear to occur and become accepted as permanent without clear analysis of their long-range impact. Moreover, from extramural sources (professional associations, the government, the public), new challenges, new opportunities, new money and new responsibilities appear daily in bewildering profusion and few schools can resist the lure. Thus we find ourselves engaged in activities for which we are ill-prepared, and lengthy commitments are made in piecemeal rather than reasoned fashion.

Perhaps the time is ripe for the suggestion of a moratorium: no new programs requiring extensive changes in patterns of responsibility should be accepted until the old (post-World War II) efforts have been fully digested, evaluated and understood.

John Corsan has stated "The dean presents the last line of defense in protecting the integrity of the university's educational program . . . Unless deans exert positive direction . . . the program of the institution becomes segmented."[6] The problem is that medical school deans have multiple responsibilities and are often required to act in terms of one set of values and objectives (the educational and research dimension) and sometimes in terms of another (the hospital, patient care, and community dimension). It is quite simple (and also naive) to say that a nice balance should be sought between the two dimensions, that the medical school administrator should attempt to exert himself in both areas of responsibility without sacrificing either.

TIME HAS DEMONSTRATED that this is impossible, and that there is something manifestly wrong in an organization which requires a complete change of management each five or six years, on the average. One dean of a West coast medical school was interviewed by the local newspaper when he decided to give up the reins and return to the laboratory. He frankly admitted to the reporter that he had been disappointed by his failure to successfully work out necessary affiliation arrangements with certain hospitals. When the reporter persisted and asked what traits his successor (still being sought) should have in order to solve the problem, the dean looked pensively out the window for a long moment and then answered "like Jesus Christ."

And here we come face to face with the parallel to Wagner's quotation ("The demands upon the orchestra have increased of late, their task has become more difficult and more complicated"). Like Wagner who blames the trouble upon "the shortcomings of the conductor," the faculty, the university, hospital administrators, and medical societies are apt to charge off the shortcomings of the system to the inadequacy of the dean who in reality may be almost powerless in the face of "demands" and "complications."

It must be stated finally that the best medical schools are not necessarily the most highly organized nor is the vague shibboleth known as "better business organization" likely to yield any real change. We already have a regimental superstructure of vice-presidents, deans, sub-deans, directors and department chairmen, each of whom does three of four different jobs with varying degrees of interest, spontaneity, and competence. It is likely that each has been drawn to an administrative position because of the challenge involved. This challenge usually is related to the idea that each man can alter the system in some definable way, that as a consequence of the singularity of his efforts, his imprimatur will be visible for all to see.

The truth is that medical schools today are being asked to or are asking for far too much responsibility for health care, often to the detriment of their original charge as educational institutions. No other school in the university is routinely expected to play so active a role in the community, and none is so likely to become strangulated by new demands as the medical school.

The combination of internal and external forces focusing on the institution creates top-heavy administrative responsibility, and the wary dean turns to assistants for help. Because they are likely to be scientists, much like himself, they, too, fast become innundated by the perplexing details of business, accounting, budgeting and real estate practice, and a move is usually made at this time to bring in business specialists. This effort, well-reasoned on the face of it, brings some temporary help, but it, too, founders sooner or later for there is something about education in general and science in particular which is unrelated to sound business practice.

Scientific discoveries cannot be programmed, education is certainly "uneconomical" (schools spend money, not make it), its projects, costs, and values cannot be charted in any linear fashion, and the effort to bring order out of disorder by business-office techniques often results in still another complication. Even when this last stratagem is successful, it is apt to succeed in a way which makes the dean "penny-wise but pound foolish." He may well run a taut ship, but educational innovation suffers because faculty spontaniety and ingenuity are stifled.

IT IS THIS last point which brings me to the heart of the matter.

The major reason, perhaps the only reason, for the existence of administrative officers in educational institutions, is to create an atmosphere which is genuinely conducive to student learning, to faculty growth, and to scientific discovery. If the medical school dean has any competence, it is certainly in relation to the educational process, not to sound business and management practice. Attracted to his new position by the educational challenge, he becomes entrapped by organizational complexities to the detriment of all.

Few question the premise that educational institutions must preserve their own traditions while at the same time responding to the changing society which they serve.

Almost two decades of service in a medical school convince me that we guard our tradi-

tions too lightly in medical education, and perhaps have become overly responsive to new programs, innovations, and demands upon us for service.

Each new program brings new promises, new complexities, new requirements, and new responsibilities. Some offer the hope for realistic solutions to an immediate problem in a way which is consistent with the purposes of an educational institution; others are related only peripherally to our major goals.

Let us do the former when we can; let us avoid the latter whenever possible; but most of all, let us think seriously about the major objectives of a medical school and then direct our energies to the accomplishment of these tasks.

Only when we have met our first responsibility to provide the soundest and most stimulating educational environment for our students and faculty (and few of us can currently boast of such an accomplishment) are we justified in trying to undertake the overwhelming task of providing high-quality health care for the community at large. There is no question that the medical school's most effective contribution in these days of changing public expectation still lies in its ability to provide *models* of excellence which can be replicated elsewhere by those community institutions which have the time, resources, and that general responsibility.

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A Short History Of Wayne State University School of Medicine

By Leslie L. Hanawalt

The regular teaching of medicine in Detroit began in 1868, when five young physicians incorporated the Detroit Medical College. These men established their college on Woodward avenue in two surplus buildings of the Civil-War Harper Hospital, leased to them free by the Harper trustees in return for free services they rendered to Harper patients.

Though no one in Detroit dreamed of a university at that time, these five educational adventurers became unwittingly the earliest founders in the history of the colleges that constitute what is now Wayne State University.

These founders had good social and financial connections. Theodore A. McGraw's father was a Detroit merchant, as was the brother of David O. Farrand. Samuel P. Duffield's father was a prominent Presbyterian minister and George P. Andrews' a medical missionary. Edward W. Jenke, 35, the oldest of the group, was the son of an Indiana land-developer and educator and the son-in-law of railroad magnate James F. Joy. All five were on the staff not only of Harper Hospital but also of the older and larger St. Mary's Hospital operated by the Sisters of Charity near downtown Detroit.

FOR INITIAL CAPITAL they depended on subscriptions made by themselves, their relatives, and 32 other well wishers. With it they built a central structure connecting the two Harper buildings, and furnished an amphitheater lecture room, a dispensary, and space for the laboratory courses, chemistry and anatomy. After the college started, they paid operating expenses from student fees only, public support of professional schools being almost unknown in America. Like nearly all medical schools, this one paid no salaries. The faculty earned their livings by private practice.

Training for the M.D. degree consisted of courses in the seven standard fields: physiology, chemistry, anatomy, materia medica (elements of what we call pharmacy, pharmacognosy, and pharmacology), surgery, obstetrics, and practice of medicine (including dispensary work). Ophthalmology was an extra. Students had to attend two "years," that is, two four-month "regular terms." These could be augmented by a free brief "preliminary term," and, a little later, by a summer term. A student's fees for the two-year course totalled about $150. Since most of the students were not Detroiters, they had the further expense of board and room at $3 to $5 per week.

The initial faculty was twelve physicians, only three of them over forty years old. They had earned their M.D.'s at some of the best medical schools, chiefly in New York City, and all held places on the hospital staffs. Five had been seasoned in Civil War army hospitals, three had studied in Germany, several are still included in modern biographical reference books. They were motivated by desire for the prestige that went with the title "professor," for the privilege of training new doctors, and for the chance to learn by teaching. They were in earnest about improving themselves and the profession. Several had recently taken part in reviving the defunct Michigan State Medical Society, in forming the Wayne County Society, and in founding the *Detroit Review of Medicine and Pharmacy*. Those who became best known in following decades were Drs. McGraw (surgery), Andrews (principles of medicine), Jenks (gynecology), and Henry O. Walker (anatomy; later surgery).

THE FIRST STUDENT body was 48 men, 33 of whom transferred from other medical schools after a year's work and constituted the first graduating class, that of 1869. A majority of these 33 came from the University of Michigan's medical school, attracted by the superior clinical facilities that the Detroit college enjoyed in the city's hospitals. Until about the time of the Civil War, the common mode of American medical-school teaching had been "didactic," with bedside experience left to the hometown preceptorship; but now there was a strong movement toward systematic clinical instruction that went much beyond what was available under a preceptor. This is one reason why medical colleges multiplied in the cities. In the next 20 years, enrollments at the Detroit Medical College varied from 50 to 133 and graduating classes from 14 to 43.

A rival, the Michigan College of Medicine, was founded in 1879 on the lower east side of Detroit by a group of doctors in much the same way as the earlier college had been formed. Intense rivalry ensued between the two schools until 1885, when they merged, becoming the well-known Detroit College of Medicine. This institution thrived and in 1889 constructed on St. Antoine street, across Mullett from St. Mary's, a large new building which stood until 1960 and is remembered by many readers of *Michigan Medicine*.

About this time, in the midst of national prosperity and optimism, the college trustees conceived the amazing idea of forming a university, including a division of liberal arts. The first steps (1891) were a Department of Veterinary Surgery, another of Pharmacy, and a third in Dental Surgery. The financial panic of 1893 demolished the university plan, but the three new departments endured respectively till 1899, 1905, graduating a total of 590 men and women in pharmacy and dentistry. They of course augmented the enrollment of the college; and since the Medical Department also grew fast, in the late nineties the student body often ran more than 400 and a year's graduates more than 100. The ancillary departments were closed by the trustees for financial reasons; they could not pay their way on student fees, and thus became a burden on the Medical Department.

THE HEYDAY OF THE Detroit College of Medicine was the 1890's. By that time medical science was being revolutionized. European research of preceding decades, publicly subsidized, was beginning to pay off. The work of Virchow, of Pasteur and Koch in the bacterial causation of many common diseases, and of Lister in antiseptic surgery routed the old simplistic disease-theories of Benjamin Rush and others, and became the foundation of the sciences of bacteriology and pathology. The new concepts became systematized in textbooks. Vaccines, antitoxins, public-health measures, and other weapons against disease caught the imagination of the public, which felt a new confidence in its physicians.

The M. D. course of study at the Detroit College was lengthened to four years in 1895; new laboratories crowded the main building and a second that was completed in 1897; German-trained teachers grew in numbers; internships, though not required by colleges or licensing boards, began to appear; and the marvelous possibilities of the x-ray—the third great medical boon of the 19th century after anesthesia and the germ theory—began to be dimly perceived. Curricular standards constantly rose.

The necessity of expanding science instruction meant, however, that financially the old colleges could no longer subsist on fees. Laboratory teachers had to spend so much time at the colleges that their private practices suffered, and the colleges increasingly had to pay them salaries. Dozens of colleges closed, and others joined universities in order to get support. The Detroit College of Medicine attempted sporadically until 1917, generally with the encouragement of the state medical society and some of the Ann Arbor faculty, to make an alliance with the University of Michigan's medical school; but the University's regents resisted the separation of any instruction from the campus in Ann Arbor.

IN 1913 THE college reorganized and reincorporated as a non-proprietary institution and raised a considerable fund, chiefly among alumni, to improve the laboratories and pay several full-time salaries in the basic sciences; but this money did not last long. Early in 1918, to preserve the college for the wartime production of doctors and for incorporation into a future municipal university, Detroit's Board of Education, by an arrangement unique in the United States, took over the debt, property, support, and control of the college.

In these early decades of the century, many teachers came into the faculty who were destined to long terms of service. Among them were Dr. Charles D. Aaron, Raymond C. Andries, Max Ballin, John N. Bell, Andrew P. Biddle, William

AUTHOR

Professor Hanawalt has been a member of the Wayne faculty for 38 years and is now the WSU historian. He is the author of the recent **A Place of Light,** the history of the University published by the WSU Press.

E. Blodgett, Frederick G. Buesser, Don M. Campbell, J. Henry Carstens, Fred H. Cole, James E. Davis, William M. Donald, Hugo A. Freund, Charles G. Jennings, Louis J. Hirschman, B. Raymond Hoobler, Augustus W. Ives, Charles S. Kennedy, Guy L. Kiefer, Dean Walter H. MacCraken, William C. Martin, Angus McLean, Richard E. Mercer, Stanley G. Miner, Grover C. Penberthy, J. Milton Robb, William J. Seymour, Dean Burt R. Shurly, William J. Stapleton, Jr., Frank B. Walker, H. Wellington Yates.

The years between World War I and 1935 were a time of difficult struggle, under Dean Walter MacCraken. Annual budgets rose from $50,000 to $240,000 and enrollments from 136 to 401; clinical teaching in the hospitals, notably in the new Receiving Hospital, became better systematized and controlled; admission and graduation requirements were raised in accord with national standards; a new six-story building relieved the pressure on the two old ones; some original research was attempted.

THE DEPRESSION YEARS brought new crises and new challenges to the medical school in its efforts to match rising standards and costs in medical education. From 1936 and the deanship of Raymond B. Allen dates the School of Medicine's rise in stature and national status.

To describe this rise would require a separate article. Key men in it have been Deans Allen, Gordon H. Scott (now a University Vice-President), and Ernest D. Gardner — and one is tempted to begin listing also a score of other veterans such as Gordon B. Myers, Osborn A. Brines, Charles G. Johnston (all deceased), Arthur H. Smith (retired), Muir Clapper, Fred L. Rights and Walter H. Seegers.

One revealing index of growth and change is the annual budget, which in 1966-1967 mounted to $10.9 million. Registration figures provide another barometer. This fall there are 536 men and women enrolled in the undergraduate medical program. Another 200 students are enrolled in medicine-related bachelor's programs and graduate programs leading to the Ph.D. and master's degrees.

CURRENTLY THERE ARE 300 fulltime faculty members and research associates. In addition, the School secures the invaluable parttime services of 80 faculty members and research associates, and nearly 900 voluntary faculty members.

Alumni of the School of Medicine now number 3,042, including the 100 graduates who received their Doctor of Medicine degrees last June. Sixty-seven per cent of Wayne's medical alumni are in practice in the State of Michigan.

The School maintains affiliations for teaching and research with Detroit General Hospital (Receiving and Herman Kiefer Branches), The Grace Hospital, Children's Hospital of Michigan, Child Research Center of Michigan, Harper Hospital, Lafayette Clinic, The Rehabilitation Institute, Detroit Institute of Cancer Research, Hutzel Hospital (formerly Woman's Hospital), Sinai Hospital, Veterans Administration Hospital in Dearborn, Wayne County General Hospital in Eloise, Hurley Hospital in Flint, St. Luke's Hospital in Saginaw, and Borgess Hospital in Kalamazoo.

As compared with 1936, the physical plant of the School has changed beyond recognition. The two 19th-century structures were abandoned in 1954 and replaced by a building for the Department of Occupational and Environmental Health, which stands alongside the 1927 library-laboratory building on Mullett Street. Eastward on the Chrysler Freeway is the large Medical Science Building in 1954 transformed the School's general teaching environment.

FAR TO THE NORTH of the present medical campus is the emerging Detroit Medical Center where Wayne is building its new medical complex. First structure to go up was the $4 million Medical Research Building, completed in 1964. The new Basic Science Building, scheduled for completion in 1970, will house six of the School's 24 departments and will allow an increase in the entering class of medical students from 130 to 200.

Plans for the School also call for a $2 million medical library, an outpatient clinic capable of serving 250,000 patients a year, a conference center, a gerontology center, a vivarium, and parking structures. Total cost of the new medical campus, covering some 25 acres is estimated at $56 million for land, present and proposed buildings.

Few medical centers in the United States will match Detroit's. Thus within a half-dozen years, the Wayne State University School of Medicine will be the unifying feature of such an investigative and therapeutic complex as the five founders, a century ago, could not in their wildest dreams ever have imagined.

Pneumoconiosis - Diagnostic Considerations

ARTHUR J. VORWALD, M.D., Ph.D.
DETROIT

In a broad sense, the term "pneumoconiosis" connotes only a pulmonary condition provoked by the inhalation of particulates, but without implications concerning subjective and objective medical findings. There is some divergence of opinion regarding that connotation. Accordingly, the term is used often in a more restricted sense which implies that the inhaled particles are toxic, and thereby have causal and/or aggravative relationships to the pathology in the respiratory tract and lung and to the attending clinical manifestations.

In any event, the diagnosis of a pneumoconiosis necessitates consideration of a number of variable factors. These may operate independently or in combination, concurrently or sequentially, to determine whether or not the inhaled particulates play a role in the anatomical and functional status of the lung.

In view of the above, a framework of some considerations is presented, with the hope that it may be useful to the physician confronted with the diagnosis of a pneumoconiosis. It is recognized that many of the considerations are part of the general survey of a patient, while others may require the assistance of specialized consultants. The framework is as follows.

The Particulates

(Collected from the Atmosphere at the Breathing Level of the Exposed Subject)

1. Judgment as to whether the particulates originate from the general atmosphere vs. that from occupational situations.
2. Physical character of the pollutant:
   a. Size distribution, especially those within respirable range, usually less than 10 microns in diameter for spherical particles.
   b. Density of particles.
   c. Surface area.
   d. Capacity to adsorb and/or absorb other atmospheric constituents.
   e. Shape: spherical or elongated.
   f. Hardness and sharpness.
   g. Radioactive properties.
3. Chemical nature:
   a. Pure or mixed.
   b. Solubility vs. insolubility.
   c. Acidity or alkalinity.
   d. Reactivity: oxidation, reduction, formation of other substances while suspended in atmosphere.
4. Biologic activity:
   a. Animal vs. man.
   b. Target tissue.
   c. Local or systemic.
   d. Toxic vs. non-toxic.
5. Atmospheric concentration: a consideration which operates to determine, in part, the pulmonary concentration in unit period of time; host factors also play a role.
6. Threshold Limit Values: the hazardous atmospheric concentrations have been prescribed for many particulate substances.

The Exposed Subject

1. Subjective findings:
   a. Occupational history; detailed for lifetime worked: when, where, how and dura-

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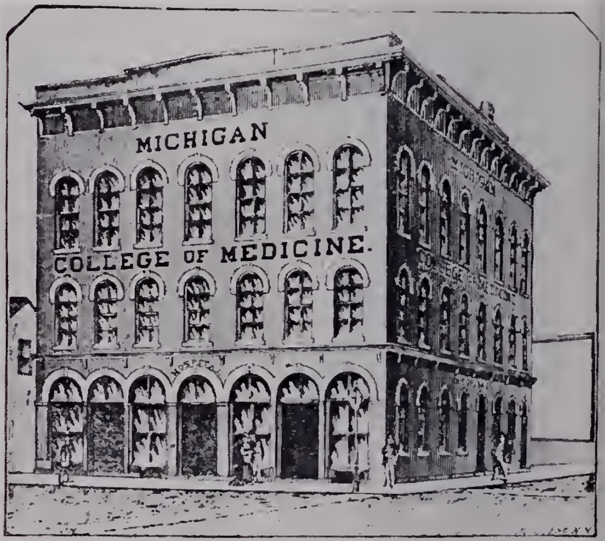
tion; exposure: when, where, how and for how long.

- b. Social history: smoking, alcohol.
- c. Detailed medical history: familial and personal.
- d. Present medical complaints: onset and duration.
- e. Time relationships between the above.

2. Objective findings:
    - a. General health status for detection of abnormality which may or may not have reference to the inhaled particulates.
    - b. Detailed physical examination, not only of the chest, but of the entire body.
    - c. Chest fluoroscopy and roentgenography, especially as they may pertain to serial studies made periodically prior to, concurrent with, subsequent to the exposure and at the time of examination. Every technical advantage should be employed to attain the best possible roentgen visualization with a maximum of blurring and with a suitable level of contrast and density which will clearly depict the details in the lung fields.
    - d. Laboratory studies: certain procedures are helpful in evaluating a diagnosis, especially in relation to a pneumoconiosis and in establishing the presence of a complicating disease.
    - e. Electrocardiogram: in a certain percentage of cases, it may be helpful for the support of a diagnosis of cor-pulmonale or right ventricular strain possibly imposed by increased intrapulmonary tension which may attend a pneumoconiosis. The study is important in all patients with dyspnea.
    - f. Cardiopulmonary function: certain pneumoconioses are characterized by functional impairments of the lung. Often, detailed studies are required for qualitative and quantitative evaluation.
    - g. Pulmonary biopsy which is representative of the diseased area, which anatomically is guided by the suspected diagnosis and which is sufficient not only for histopathology, but also for chemical analysis.

The criteria deemed essential for the diagnosis of a pneumoconiosis may be stated as follows: 1) there must be history and unequivocal evidence of exposure to the inhalation of particulates with awareness that some particulates are biologically inert and non-toxic, while others are active and toxic, and that pulmonary concentration and retention are important issues; 2) the medical history and complaints should be consistent with the time and duration of exposure and with the known toxicity of the particulates involved; 3) the objective medical findings have to be compatible with the histories of exposure and of illness and with the medical complaints. Finally, the diagnostic considerations include a mindfulness of the fact that the exposed individual is not immune to cardiopulmonary impairments which also afflict subjects of the general population and which may have no causal and/or aggravative relationships to the exposure.

Another WSU Photo From Yesteryear



The Michigan College of Medicine, at St. Antoine and Catherine, was started in 1879 and merged in 1885 with the Detroit College of Medicine, and became in 1913 the Detroit College of Medicine and Surgery.

Pneumonias Caused by Gram-Negative Bacilli

BY A. MARTIN LERNER, M.D.
JAMES R. TILLOTSON, M.D.
BOTH OF DETROIT

The work was aided by a grant (5 T1 AI261) from the National Institutes of Health.

In 1963 it was noted that pneumonias were occurring which seemed to be caused by gram-negative bacilli which had been thought uncertain or, perhaps, rare determinants of disease of the lower respiratory tract.[1]

Since these "unusual" respiratory bacilli appeared repeatedly in sputa, empyema fluids, or bloods and in pure culture or as the predominant organisms; and, moreover, since prior administration of antibiotics which might have induced such a flora had not been given; and, finally, since standard sources were not helpful in predicting clinical courses in the affected patients; further data were collected. Half of these afflicted reached the Stygian shore, and the pneumonias seemed new "captain (s) of the men of death."[2]

It was posed that as with pneumoccal or Friedländer pneumonias these "unusual" pulmonary pathogens, because of their intrinsic biological and biochemical individuality,[3] should occur in favorable clinical milieu and produce characteristic illness. With definition, this has proved true.

The diagnoses of *Escherichia coli*, pseudomonas, proteus, bacteroides, or hemophilus pneumonias were made in 53 patients who were seen during a period of 30 months from July, 1963 through December, 1965 at Detroit General Hospital.

IN EACH, A GRAM-NEGATIVE bacillus had been recovered from 2 or more consecutive sputa or isolated from sputum and blood, both specimens having been obtained on the same day. Similarly the bacterium might have been recovered from sputum or blood and pleural fluid. When a concomitant bacteremia had not been confirmed, improvement after addition of an antibiotic which was effective against the implicated gram-negative bacillus, was accepted as a diagnostic aid. When the courses of the patients were not completely compatible, the case was excluded from the series.

THE GROUP WERE persons in their later middle years (mean age, 53). Moderate to severe chronic disease of the lung (bronchitis, bronchiectasis, emphysema, or asthma) was important in aspirations of oropharyngeal contents and subsequent pseudomonas, proteus, hemophilus and most of the bacteroides pneumonias. These bronchial embolisms of bacteria and mucus tended to lodge and subsequently involve posterior segments of upper and apical segments of the lower lobes.[4]

Heavy cigarette smoking was usual in these pneumonic patients with chronic lung disease. Alcoholism and convulsive disorders, conditions altering the state of consciousness, favored aspiration, and were commonly noted.

Most patients acquired their infections outside of the hospital and were not receiving antibiotics at the times they became ill.

Other patients had normal lungs. Notably these pneumonias were due to *Escherichia coli* or bacteroides. Bacteremias preceded the pneumonias which usually affected lower lobes. "Colon baccillus" pneumonia occurred in patients with urinary tract infections (often with diabetes mellitus). Others with *E. coli* pneumonia had gastrointestinal infections or bowel surgery facilitating bacteremia. Women with pelvic conditions (e.g., tubo-ovarian abscess, postpartum endometritis, induced abortion) developed bacteroides, bacteremia and pneumonia.

Unlike pneumococcal but similar to Friedländer's pneumonias, *Herpes labialis* did not accompany these unusual gram-negative pneumonias. Hospitalizations were protracted (often 6 weeks or more) and management difficult.

Escherichia coli (see table) pneumonias were most frequent of the "captains" (20/53, 37.8%). They were lower-lobe bronchopneumonias; empyemas often developed about the 6th day in the hospital.[5] Multiple resistances to antibiotics were commonplace. Although its use often had to be prolonged and fraught with dangers of oto- or nephrotoxicity, kanamycin was the most uniformly effective antibiotic. In fatal cases (12/20, 60%) interstitial pneumonias with mixed cellular infiltrates, engorgement of capillaries, and edema within and deposition of fibrin along the alveolar walls were usual.

BACTEROIDES PNEUMONIAS followed bacteremias (3/11) or aspirations (5/11). Bacteremias were the result of anaerobic infections in the

CLINICAL FINDINGS IN ADULTS WITH PRIMARY GRAM-NEGATIVE PNEUMONIAS

BACTERIA	PATIENT	PREDISPOSING CONDITIONS OR CHRONIC DISEASES					PATHOGENESIS ASPIRATION (A) OR BACTEREMIA (B)	CLINICAL	THERAPY OF CHOICE, 1967
		LUNG	HEART	PYELONEPHRITIS	DIABETES MELLITUS	OTHER			
1) **Escherichia coli**	Middle-aged, 12/20 men (mean,53 yrs)	—*	±	+	+	Often have gastrointestinal infection or surgery	B	Lower lobe bronchopneumonias with metapneumonic empyemas	Kanamycin, 10-15 mg/kg/24hrs. (total dosage not to exceed 12-15 gm)
2) Pseudomonas	Elderly men (mean,59 yrs)	+	±	—	±	None	A	Nodular lower lobe pneumonias with coalescing microabscesses (cyanosis, confusion, relative bradycardia, reversal of diurnal temperature curve, azotemia, abnormal liver function)	Polymyxins (3-5 mg/kg/24 hrs); Gentamicin (2.4 mg/kg/24 hrs)
3) Proteus	Middle-aged to elderly mean,59 yrs)	+	±	—	±	Alcoholism frequent; (altered state of consciousness (e.g., delirium tremens, coma, . . .) predisposes to aspiration	A	Dense lobar pneumonia with multiple abscesses	Kanamycin (see **E. coli**); Penicillin G or Ampicillin for strains of **P. mirabilis**
4) Bacteroides	Women with pelvic infections	—	—	—	—	Acute or subacute pelvic infections	B	—acute illnesses Lower lobe bronchopneumonias, with empyema, sometimes with abscess	Correction of pelvic condition (often surgery) plus thoracenteses or thoracotomy with tube drainage plus antibiotics
	Middle-aged, predominantly male mean,54 yrs)	+	±	—	—	Alcoholism common, carcinoma of colon	A/B	—subacute illnesses Lower lobe bronchopneumonias, with large rapidly recurring empyemas	Thoracotomy with tube drainage plus antibiotics: Penicillin (aqueous) (10-20,000/U/24 hrs. I.V.) or Tetracycline, (1-1.5 gm/24 hrs. I.V.)
5) Hemophilus influenzae A. Segmental	Infants, occasionally children, rarely adults	—	—	—	—	Infection with type b in persons without circulating bactericidal antibody	A	Lobar pneumonias indistinguishable from pneumococcal pneumonias	Ampicillin (30 mg/kg/24 hrs, I.M.); Tetracycline (12 mg/kg/24 hrs, I.M.)
B. Bronchopneumonias	Middle-aged persons, ⅔ men	+	—	—	—	Infection with any of smooth or rough forms	A	Diffuse miliary bronchopneumonias	

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* **Code:** +, usually present; —, usually absent; ±, sometimes present

pelvis of young or middle-aged women with normal lungs. The rest of these putrid pneumonias occurred in elderly men with significant chronic pulmonary disease.[6] Both groups had bronchopneumonias and early empyemas. Following bacteremia, abscesses in the affected lungs and a more hectic illness were common, while larger and rapidly re-accumulating empyemas were characteristic of the rest. These bronchopneumonias with prepneumonic and often massive empyemas are reminiscent of beta-hemolytic streptococcus pneumonias.[7] At microscopical study of the fatal cases, bacteroides pneumonias were patchy intra-alveolar and interstitial mononuclear infiltrates. Nonetheless, exudates of the empyemas were polymorphonuclear. Surgical correction of pathology within the pelvis, thoracentesis, or thoracotomy with tube drainage and tetracycline were all effective and necessary modalities. Tetracycline was used intravenously at a dosage of not greater than 1.0-1.5 grams per day.

Infection with pseudomonas occurred in patients with more severe chronic lung disease than that of the other gram-negative bacillary pneumonias; of these 10 patients, 8 died. Pseudomonas pneumonias were diffuse nodular infiltrates forming coalescing cystic abscesses reminiscent of staphylococcal bronchopneumonia.[8, 9] Cyanosis, confusion, relative bradycardia, reversal of the diurnal peaks in fever, azotemia, and hepatic malfunction punctuated these maladies. At autopsy, microabscesses and focal hemorrhage within affected areas of the lung were evident.

Unlike fatal cases of pseudomonas bacteremias in which the lungs may be secondarily colonized, pulmonary vessels were patent and their media devoid of a necrotizing bacillary vasculitis. Severe toxicity and aberrant functioning of the liver and kidney, as well as focal polymorphonuclear accumulations within these organs at death, may well have been induced by circulation of several toxic enzymes elaborated by pseudomonas; namely, elastase, hemolysin, lecithinase, and lipase. Polymyxin B (1.5—2.5 mg/kg/day) or E (colistin, 3-5 mg/kg) or gentamicin (2.4 mg/kg)[10] are required, but, nonetheless, most patients died.

PROTEUS PNEUMONIAS occurred in 6 severe alcoholics with moderate chronic lung disease. All contracted pneumonias following periods of stupor or delirium. They were dense lobar consolidations with multiple abscesses. Kanamycin again was the drug of choice.[11]

Hemophilus, like pneumococcal pneumonias in children, are segmental or lobar infiltrates. Increasingly common, however, are diffuse miliary bronchopneumonias in middle-aged or elderly persons with underlying diseases of the lung.[12] Hemophilus pneumonias in adults are benign and may be caused by typable (smooth) or non-typable (rough) stains. Intrathoracic complications are

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rare. They respond promptly to moderate administrations of ampicillin or any of the tetracyclines.

Gram-negative bacillary pneumonias occur today and seem to be increasingly frequent. Recognition of their distinguishing qualities allows application, however difficult, of appropriate therapy, and offers the only hope of a sanguine outcome.

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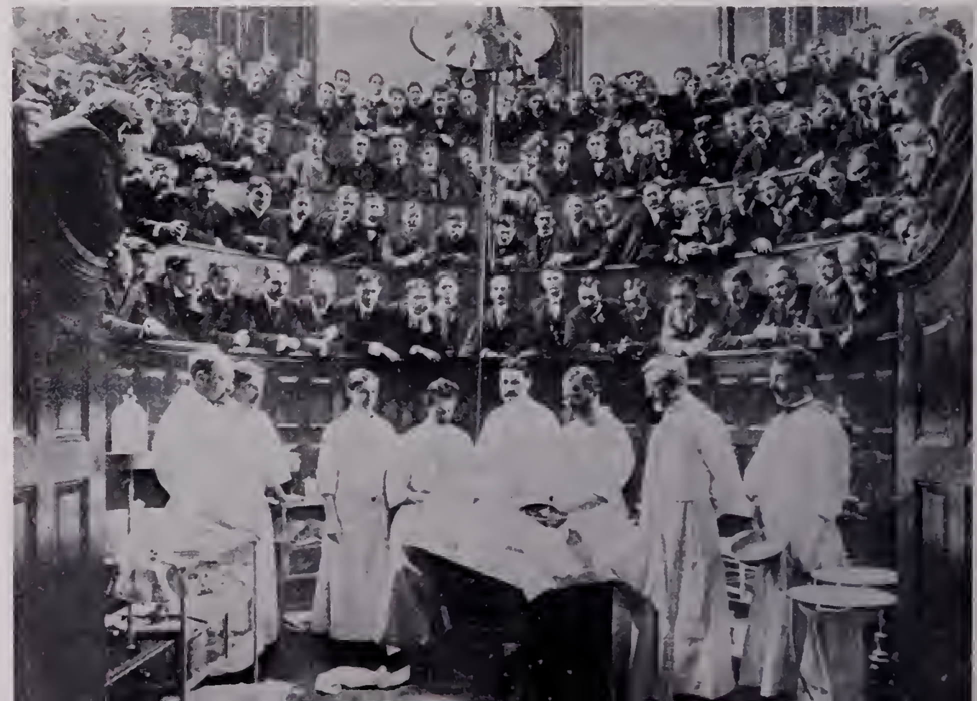
This old photo from the WSU files shows students of the Detroit College of Medicine in 1898 watching an operation in the operating room of St. Mary's Hospital, now Detroit Memorial.



Photosensitizing Drugs, Plants and Chemicals

BY DONALD J. BIRMINGHAM, M.D.
DETROIT

Sunlight is one of nature's most exhilarating attractions. Thousands seek out its rays as a means of relaxing and improving their physical well being and even greater numbers fanatically pursue the sun for the expressed purpose of acquiring the coveted emblematic tan. Sunburn is a frequently experienced by-product of this mania and among those with a feeble tanning mechanism, freckling becomes their only naturally manufactured tan.

It is now common knowledge that a poor tolerance to sunlight leads to premature aging of the skin, the development of actinic keratoses and later cutaneous cancers on the sites of repeated sun exposure. Besides these frequently observed actinic effects upon skin, there is an extremely unique but less commonly occurring group ot reactions due to the phenomenon of photosensitization.

BASIC CAUSAL FACTORS in some of the photosensitivity disorders arise from genetic, nutritional or metabolic aberrations while other photosensitivity effects stem from contact with one or more of a growing list of chemicals, plants and drugs which potentiate the action of sunlight. It is the latter group which is the basis of this review.

Cutaneous photosensitivity caused by certain photoreactive plants was recognized long ago. Later, dyes as Eosin and others contained in therapeutic agents were found to possess specific photosensitizing qualities on skin. Similarly, several chemicals encountered in the work environment were found to injure the skin in the presence of ultraviolet or sunlight exposures. Much of the present interest in photosensitization has stemmed from the increased frequency of photodermatoses attending the use of several drugs.

Clinical alertness in recognizing these reactions has not only enhanced the reservoir of clinical data, it has led also to technical advances in laboratory diagnosis and research pointed toward better definition of the mechanisms at work. Indeed, there are few areas in dermatology where biologists, chemists, physicists, and clinicians have been better able to pool their talents.

Photosensitization is defined as a process within a cell, tissue or organism which has been acted upon by a substance that renders it sensitive to a particular region of the spectrum to which it was previously insensitive. In other words, wave lengths of light — ordinarily considered as only mildly, if at all, capable of causing a reaction in skin — become extremely active in the presence of a photosensitizer. The potentiator or photoreceptor can be an ingestant, an injectant or a contactant. Whichever the route of entry, there occurs an exaggerated reaction of the skin to sunlight due to the photosensitizer residing in the epidermis. The biological events which culminate in the reaction are not clearly established, but it is assumed that once the photosensitizer absorbs the light there begins an energy transfer within the skin. (Energy may be transferred into heat, molecular excitation, molecular dissociation, fluoresce, phosphorescence or free radicals. A free radical is a molecule with unpaired electrons.)

THE DEGREE OF cutaneous insult depends upon several factors which include the type of photosensitizer, its potency, its concentration, the degree of exposure to light, and the natural tolerance of the individual to light. What happens at the cellular level may depend upon the particular focal site of the photosensitizer. Recently investigators in England have shown that some photosensitizers remain at the cell membrane while others concentrate within the lysosomes. Thus, they suggest two types of photosensitization: one being due to increased permeability of the cell membrane; the other arising from increased permeability of the lysomal membrane with subsequent release of lytic enzyme. In either case, cell injury or cell death can occur. Several of the photosensitizers are tricyclic in chemical structure and many of them fluoresce. They are activated by their own specific wave lengths of light, usually in the 2800 to 4300 Å range. Some of the dye materials react to wave lengths in the visible spectrum 3900 to 7900 Å. None of the photosensitizers is actuated by infra red.

Phototoxic versus Photoallergic

Photosensitization reactions can be phototoxic or photoallergic. Those based on phototoxicity are the most frequently observed, being somewhat analogous to cutaneous reactions induced by primary irritants. In other words, any one will react to a phototoxic agent following the initial exposure if sufficient amounts of the photosensitizer and light are present. The combined action of the photosensitizer and the light rays promptly produces a toxic reaction within 24 to 48 hours. The resultant clinical change can be a wheal or pronounced erythema or vesicles or bullae. Varying degrees of hyper- or hypo-pigmentation result.

Photoallergic reactions are much less common than those due to phototoxicity. Further, they have a different pathogenetic mechanism. When a sensitizable individual encounters a photoallergen and sunlight, the immediate effects are not generally observable. The light stimulus acts upon the photoreceptive chemical and brings about a structural change which then imparts to the chemical a pro-allergen capacity. Once this change occurs the altered chemical can combine with protein to form a complete antigen and sensitization ensues. When the sensitized level has reached the optimum peak, usually within an incubation period of 5 to 7 days or more, further exposure to the photosensitizer and sunlight induces a reaction. Time, therefore, is an important difference associated with this photo-effect.

Clinical Features

Clinically, dermatoses due to photoreactions dependent upon chemicals, plants or drugs appear on the exposed areas of the body. Drug induced photodermatoses are usually more extensive than those caused by chemical and plant photoreactors, but this is not unequivocal because extensive contact can occur with chemical agents or plants. Irrespective of the cause, the face; anterior neck (V); dorsal surface of the hands, forearms and lower arms are generally affected. If exposure conditions permit, the back and lower extremities similarly can be involved. The scalp is rarely attacked because hair is a natural protection. Other sites which are spared because of natural protection from sunlight are the upper eyelids and the submental area. Not infrequently the watch band will serve as a protector; whereas the left hand and forearm, as well as the left side of the face and neck, may show intensified effects from exposure while driving an automobile.

Morphologically, the lesions can assume a variety of appearances. They may be mildly or severely erythematous, eczematous, bullous, lichenoid or urticarial. Often the inflammatory and vesicular eruptions eventuate in hyperpigmentation, whereas bullous lesions usually lead to hypo-pigmentation. Both of the pigmentary disturbances can persist for months.

Drugs

Since the mid thirties there has been a steady flow of information on drugs associated with photosensitization. The sulfonamides became established photosensitizers when used topically or systemically. None of them, however, was as reactive as the original product — sulfanilamide. Drugs related to the sulfonamides, notably the sulfonylurea oral antidiabetic agents, have been associated with

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photosensitivity reactions. Both chlorpropamide (Diabinese) and tolbutamide (Orinase) are believed to have induced photoallergic effects. Sulfonamide related drugs used as diuretics similarly have caused photoreaction, for example, both chlorothiazide and hydrochlorothiazide were found to act as allergens.

Numerous photoreactions were reported from several of the phenothiazine derivatives. Phenothiazine was used as an insecticide more than 25 years ago and at that time it caused photosensitivity reactions among the sprayers coming into contact with it. Now there is ample evidence that similar preparations, namely, Thorazine, Sparine, Compazine, among others, are effective photosensitizers. About two years ago there were reports describing bluish-gray pigmentation among psychotic patients receiving high and prolonged dosage of Chlorpromazine. The intense discoloration occurred from the chemical combination of melanin and Chlorpromazine.

Among the antibiotics, Demethylchlorotetracycline (Declomycin) and Griseofulvin have caused photoreactions. More recently there have been many reports of photo-effects from certain antibacterial agents, notably those identified as halogenated salicylanilides. Bisphenol also was found to be an active photosensitizer. The first of these, tetrachlorsalicylanilide, was noted to produce photo-effects among a group of workers in a British factory where the substance was being used in an industrial soap. It was found to also cause contact sensitization. Tribromosalicylamide, used as an antibacterial in soap, has caused similar reactions. Bithionol (Bisphenol) formerly had a wide usage in toilet soaps, shampoos, deodorants, among other cosmetic preparations; but its unexpected behavior as a photosensitizer caused its discontinuance as an antibacterial in cosmetics.

A recently reported photosensitizer is the artificial sweetener — Cyclamate. Its photoreceptive action was first reported in Japan and lately in this country. Chemically, Cyclamate is a sodium or calcium salt of cyclohexylsulfamate. Here, again, is a compound related to the sulfonamide group. In short, there are well over 100 drugs which have become associated with untoward reactions in the presence of sunlight. Many of the photodermatoses due to drugs are believed to be allergic.

Accepted criteria for differentiating between drug photoxicity and photoallergy were proposed by Baer, with certain modifications by Harber:

PHOTOTOXICITY	CRITERION	PHOTOALLERGIC
+	First exposure.	0
0	Incubation period.	+
0	Chemical change in photosensitizer.	+
Sunburn-like.	Clinical changes.	Varied
0	Flares at previously involved distant sites.	+
0	Persistent reaction to light.	+
0	Cross-reactions.	+
High	Concentration of drug required for reaction.	Low
High	Incidence.	Low
Usually similar to absorption spectrum.	Action spectrum.	Usually higher than absorption spectrum.

Although these criteria were set forth as applied to drugs, they can be applied equally well in differentiating between phototoxic and photoallergic reactions due to chemicals or plants.

Plants

Some of the most fruitful research in photosensitivity has come from studying phytophotodermatitis, in general, and the furocoumarins, in particular. Years ago it was noted that eau de Cologne caused hyperpigmentation of the skin. Next it was ascertained that sunlight was a necessary factor. Later it became evident that most plants possessing photoreactive capabilities belonged to the family, Umbelliferae, which includes wild parsnip, cow parsnip, parsley, celery, wild carrot, fennel, and dill.

Today we know that most of the phytophotodermatoses are due to the furocoumarins, notably the psoralens. These materials (psoralens) are extremely potent photoreactors, e.g., bergapten (5-methoxypsoralen) is contained in some colognes; 5- and 8-methoxypsoralen are present in numerous of the plants mentioned. The more active psoralens can be extracted from their plant sources or can be synthesized and then used therapeutically because of their stimulatory action on the melanocytes. Thus, they can be used in treating vitiligo and leukoderma to restore the pigment and in sun sensitive skin to reinforce the protection afforded by melanin.

A few years ago in Michigan complaints of vesicular and bullous dermatitis among the celery harvesters set the stage for a dermatologic study among these employees. It was found that harvesting the normal celery was not attended by any such difficulty; but when contact was made with pink-rot celery (infected by the fungus, sclerotinea sclerotiorum) and sunlight, vesicles and blisters appeared within 36 hours. The phototoxic psoralens contained in the diseased celery are 8-methoxy and trimethyl psoralens — both of which are highly potent. Among the plants reported to cause photodermatoses are:

Agrimony
Angelica
Blind Weed
Buttercup
Celery (Pink-Rot)
Common Rue
Dill
Fennel
Fig
Gas Plant
Goose Foot
Lime
Masterwort
Mustard
Parsley
Parsnip (Cow, Garden, Wild)
Persian Lime
St. John's Wort

(With modifications, per Pathak, Daniels and Fitzpatrick, **J. Invest. Dermat. 39: 225-239, 1962)**

Chemicals

A number of occupations are associated with hyperpigmentation of the skin. Men employed in coal tar distillation plants encounter anthracene, acridine and phenanthrene — all of which are known photosensitizers. Creosote impregnation of wood to be used for railroad ties, telephone poles, fence posts, etc., is attended by hyperpigmentation and exaggerated effects of exposure to sunlight. Coal tar pitch, paints, roofing pitch, and road tar have many applications and similarly effect many workmen. Pipe line installations cause extreme melanoderma among many of the workmen from the tar products used to weatherproof the pipe line. Workmen changing the lining of certain industrial furnaces have developed burning, itching and melanoderma of the face, neck and hands from contact with tar dust present in the linings and then subsequent exposure to sunlight.

Some chlorinated hydrocarbons, notably the chlorobenzols, chlorinated di- and tri-phenyls, and the triphenyloxides — besides causing chloracne — produce a peculiar grayish pigmentation of the light exposed areas. The number of photosensitizing chemicals encountered in industry is small when compared to the general list of chemicals contained within the work environment, but when compounded with possible exposure to photosensitizing drugs the problem is one of increasing importance.

Photosensitizing Chemicals

Acridine
Anthracene
Benzene
Chlorobenzodioxanes
Chlorobenzols
Chlorodiphenyloxides
Chlorodiphenyls
Chlorotriphenyls
Chloronaphthalenes
Coal Tar and Distillates
Coal Tar Paints
Coal Tar Pitch
Creosote
Phenanthrene
Road Tar
Roof Pitch

Summary

It is of advantage for the physician to be aware of the potential interaction of certain drugs, plants, chemicals and sunlight. Photosensitization reactions are being clinically recognized with increasing frequency. They can be phototoxic or photoallergic in nature, but most photoreactions are phototoxic. The photoallergic reactions are relatively uncommon. The photoallergic eruptions caused by contact can be diagnosed with photopatch testing techniques.

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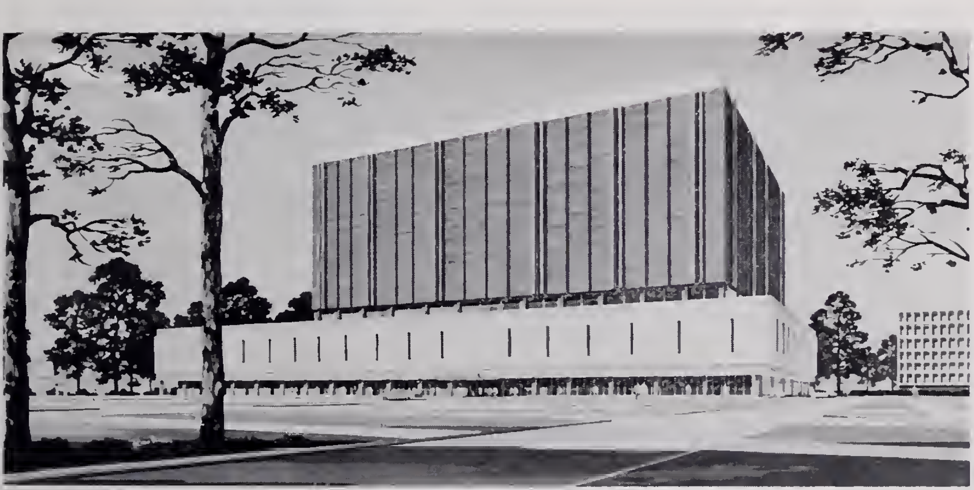

The eight-story, new WSU Basic Science Building will be located just west of the Medical Research Building. Upon completion, the new teaching facility will allow an increase in the entering class of medical students from 130 to 200.

The Spectrum of Autonomous Function In Thyroid Nodules

BY JOEL I. HAMBURGER, M.D.
SOLOMON C. WERCH, M.D.
GEORGE KADIAN, M.D.
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ALL OF WAYNE COUNTY

Scanning with radioiodine has contributed to the formulation of a classification of thyroid nodules in terms of their capacity to concentrate this tracer substance. Thyroid nodules which concentrate 131-I to a greater degree than extranodular tissue have been called "hot" nodules.[1] "Hot" nodules, however, may arise as a consequence of many different pathophysiologic processes.[2] Of these processes autonomous function, function independent of extrathyroidal stimulating factors, has been the subject of considerable attention in the medical literature.[3-5]

Most of this literature has dealt with radioisotope techniques for the demonstration of those "hot" nodules which function autonomously. Thyroid nodules of activity similar to that of extranodular tissue ("warm") may also have autonomous function.[6] Despite the fact that the suppression scan (a scan following thyroid hormone administration) has been shown to be of value in the diagnosis of "warm" autonomous nodules, this clinical test, unfortunately, has only rarely been employed. Data on the incidence of autonomous function in thyroid nodules is unavailable in the medical literature since there has been no systematic application of appropriate confirmatory tests in any sizeable series of consecutive patients suspected of having autonomous nodules.

Our experience over a period of five years (1961-1966) with a population of 3088 referred, private patients helped further our understanding of autonomous function in thyroid nodules. We believe that this experience adds to the literature in three ways:

1. It contributes a reasonable value for the incidence of autonomous nodules in all thyroid patients, and especially in those with discrete nodules;
2. It emphasizes the importance of suppression scanning in the identification of autonomous "warm" nodules;
3. It demonstrates the pictorial spectrum of the autonomous nodule.

Material and Methods

The autonomous thyroid nodules studied were selected from 3088 private patients referred to a thyroid diagnostic laboratory over a five-year period between 1961 and 1966. During this period, patients with discrete nodules (at least 1 cm. in frontal and antero-posterior projection), were scanned routinely. The distinction by physical examination between true nodularity and accentuation of the normal lobular architecture of the thyroid is admittedly difficult in some instances. Since we wished to uncover all patients with autonomous nodular function, all the discrete thyroid protruberances were accepted for study. Patients with multinodular and irregular goiters were not included in this study unless one or more discrete nodules could clearly be distinguished from the main mass of the goiter.

Preliminary scanning permitted the nodules to be divided into three groups:

1. "Cold" nodules; those with less activity than that of the extranodular thyroid tissue.
2. "Warm" nodules; those with activity similar to that of the extranodular thyroid tissue.
3. "Hot" nodules; those fulfilling the criterion of Perlmutter,[7] having 125% of the activity of the symmetrical contralateral area of the gland.

Attention should be called, at this point, to the potential error in the assumption that activity recorded in the area of the scan in which a nodule is localized actually results from radioactivity emanating from that nodule. A cuff of normal tissue in front of or behind the nodule may give a functionless nodule the appearance of being active. Hence the classification on the basis of the preliminary scan was always considered presumptive. In particular small nodules which localized to areas of function similar to that of extranodular tissue, and hence were classified as "warm," might actually have been nonfunctional. Conventional scanning classifications permit no solution to this dilemma. At this point we chose to follow the standard classification, recognizing its limitations, to permit comparison of our data with that of others. Some nodules fulfilling the criterion for "hot" nodules were excluded from the study be-

TABLE I

Incidence of Autonomous Function in 424 Discrete Thyroid Nodules in 3088 Consecutive Private Referred Patients

Type of Nodule	Number			%
"Cold" Nodules	263			
"Warm" Nodules	105			
a. Incompletely Studied		62		
b. Completely Studied		43		
1) Suppressible			30	
2) Autonomous			13	38*
"Hot" Nodules	56			
a. Incompletely Studied		22		
b. Completely Studied		34		
1) Suppressible			10	
2) Autonomous			24	70*
a) With Hyperthyroidism			10	
b) Without Hyperthyroidism			14	
Total confirmed autonomous nodules			37	48**

*Percent of those completely studied

**Percent of "warm" and "hot" nodules completely studied

cause they were obviously examples of compensatory hyperplasia secondary to previous contralateral surgery, or were associated with Graves' disease. Patients with nodules which on preliminary scan were either "warm" or "hot," unless contraindicated, were advised to have additional confirmatory scanning procedures of the following types:

1. If the preliminary scan revealed a "hot" nodule with relatively complete suppression of extranodular function, a repeat scan was done after stimulation with intramuscular TSH (five units daily for two days). The "lighting up" of the contralateral lobe seen on a repeat scan was considered confirmatory evidence for the presence of an autonomous "hot" nodule.[2]
2. If the preliminary scan revealed a "hot" nodule with considerable extranodular function, or a "warm" nodule, then a repeat scan was done after suppression with oral L-thyroxine (0.3 mg. daily for four weeks). The four-

CO-AUTHOR

HAMBURGER

ABSTRACT — Evaluation of 3088 referred, private thyroid patients showed that among 424 with discrete nodules, 161 patients had either "warm" or "hot" nodules. Confirmatory data, including suppression scanning, from 77 of these 161 patients revealed autonomous function in 37, or 84% of "warm" and "hot" nodules, and at least 9% of all nodules. Scanning provided pictorial confirmation of autonomous function in nodules ranging from large, "hot" with hyperthyroidism, to occult, "warm" and asymptomatic. Asymptomatic autonomous nodules were observed without treatment, and provided data supporting the concept that autonomous "hot" nodules producing hyperthyroidism evolve from autonomous nodules with lesser degrees of function.

week period serves both to permit decay of the initial tracer dose, and to suppress pituitary release of TSH. If the repeat scan revealed persistent 131-1 concentration in the area of the nodule, with suppression of 131-1 concentration by extranodular tissue, then the diagnosis of an autonomous nodule was considered confirmed.[2]

The suppression scan was done with caution in patients over 50 years of age, and was contraindicated in those with cardiac arrhythmia, congestive heart failure, angina pectoris or patients over 65 years of age.

Results

The types of nodules encountered are presented in Table 1 according to scanning and physiologic criteria. Discrete nodules were found in 424 patients. Among these, 263 were "cold" and were not studied further. "Warm" nodules were found in 105 patients. Suppression scans were done in 43 instances and 13 autonomous "warm" nodules were uncovered. "Hot" nodules were found in 56 patients. In 34 of these patients confirmatory scanning was done, and autonomous function discovered in 24, of whom 10 had manifestations of clinical hyperthyroidism.

Autonomous function was confirmed in a total of 37 of 424 discrete nodules for an incidence of 9%. If the same proportion of patients not tested, as those tested, proved to have autonomous function the true incidence of autonomous function would have been higher, about 13%. The incidence of confirmed autonomously functioning nodules in the entire group of 3088 patients was slightly in excess of 1%. Once again assuming that autonomous function was present in the same proportion of patients not tested, as those tested, the probable incidence of autonomously functioning thyroid nodules that may be encountered in thyroid patients in general would approach 2%.

There were 10 patients with toxic autonomous "hot" nodules. Although 24-hour 131-1 uptakes were frequently within normal limits, the PBI determinations gave values above 7Ug% in all instances. Those with lower PBI values had less obvious manifestations of hyperthyroidism. These patients ranged in age from 33 to 68 years with a mean of 54 years. Only one patient was under 40 years of age.

The nodules ranged in greatest diameter from 1.5 cm. to 8 cm. with a mean of 4 cm. The only patient which had a nodule less than 3 cm. in diameter actually had three nodules, each of which measured 1.5 cm. in diameter.

There were 14 euthyroid patients with autonomous "hot" nodules. The lesser function of these nodules, compared with the previous group, was associated with lower values on both the 24-hour 131-1 uptake and the PBI determination. These patients ranged in age from 22 to 65 years, with a mean of 48 years. Five of these patients were less than 40 years of age. These nodules ranged in greatest diameter from 1.5 cm. to 3.5 cm., with a mean of 2.5 cm.

There were 13 patients with autonomous "warm" nodules. All were euthyroid on the basis of both clinical and laboratory evaluation. These patients ranged in age from 10 to 62 years, with a mean of 43 years. Five of the 13 patients were less than 40 years of age and only one was over 60 years of age. The nodules ranged in greatest diameter from 1.5 to 2.5 cm., with a mean of 2 cm. In 7 patients the nodule was delineated on the preliminary thyroid scan from the distortion of the normal butterfly configuration. In 6 patients the preliminary thyroid scan was normal. Marks placed on the scan on the basis of the physical examination were required to localize the nodule. Suppression scanning confirmed autonomous function in all of these nodules. Extranodular function was obliterated and all residual activity localized to the area of the palpable nodule. The 24-hour 131-1 uptake in patients with "warm" nodules after suppression with thyroxine were significantly less than preliminary values. This was attributed to reduction in function of extranodular tissue.

The spectrum of autonomously functioning thyroid nodules is presented in Figures 1-6. The first patient (Figure 1 had an autonomous "hot" nodule with clinical hyperthyroidism treated successfully with 131-1. The second patient (Figure 2) had an autonomous "hot" nodule of similar size, but no manifestations of hyperthyroidism. There is a central "cold" area in this nodule. In our experience "cold" areas in "hot" autonomous nodules represent areas of degeneration. This may account for the failure of this nodule to secrete enough thyroxine to produce hyperthyroidism in spite of its considerable size. The third patient

Continued on Page 50

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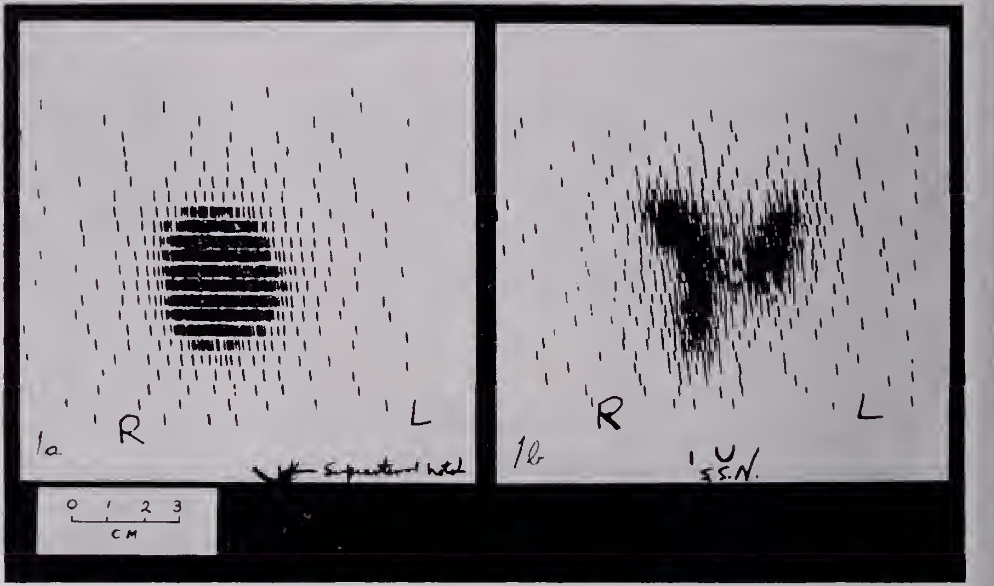
1a
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Suprasternal notch
1b
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L
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CM

Figure 1: L. T., Hyperthyroid woman. a. 24-hour 131-1 uptake 52%, nonsuppressible. Four cm. "hot" nodule right lobe. b. Three months after 50 mc. 131-1. 24-hour uptake 22%. Butterfly pattern with elongated right lobe indented by smaller, nonfunctional nodule.

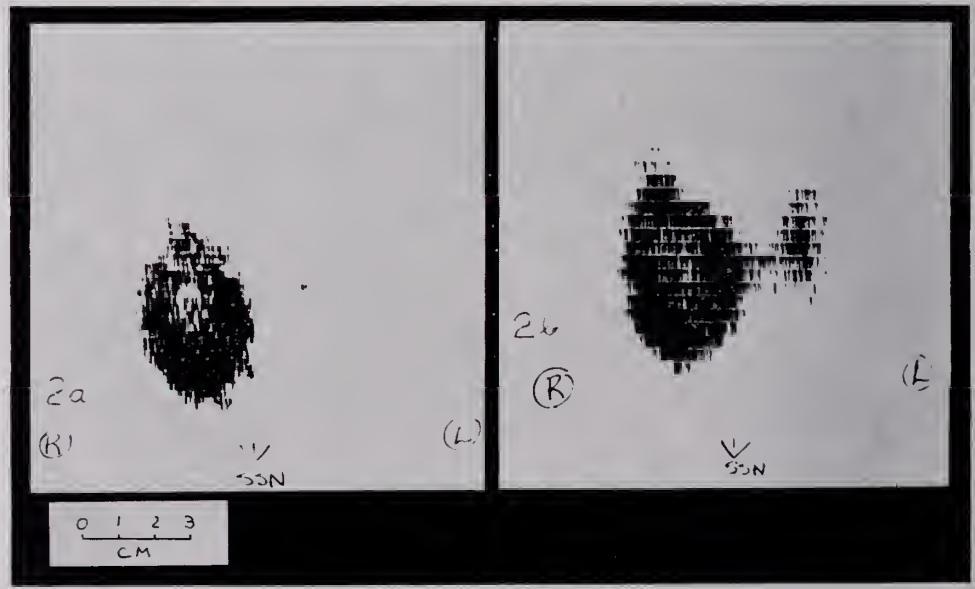
2a
(R)
(L)
SSN
2b
(R)
(L)
SSN
0 1 2 3
CM

Figure 2: R. F., Euthyroid man. a. 24-hour 131-1 uptake 23%. Four and one-half cm. "hot" nodule right lobe. b. Scan after TSH reveals "lighting up" of the left lobe.

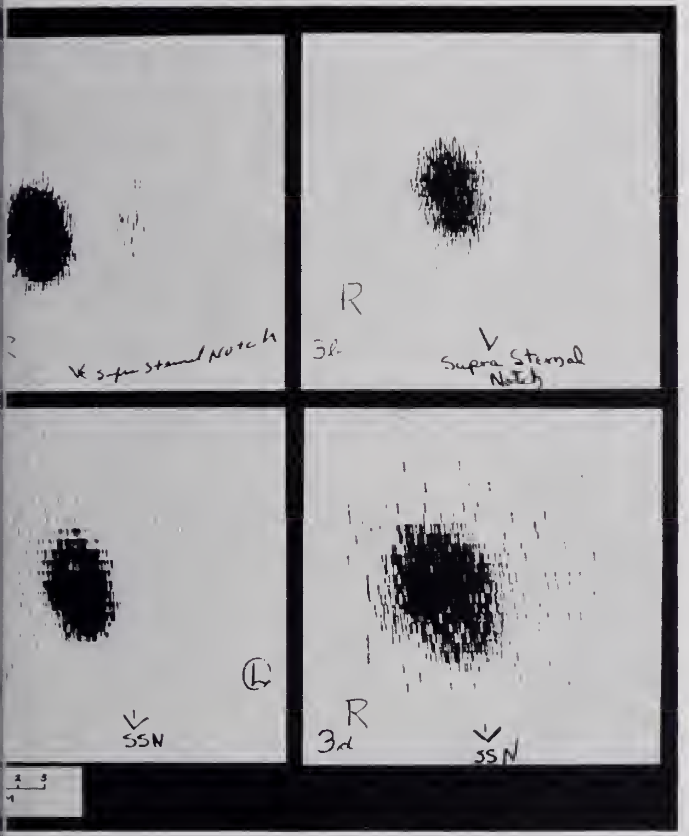

Figure 3: S. E., Euthyroid woman. a. 24-hour 131-1 uptake 22%. Four cm. "hot" nodule right lobe with some persistent function left lobe. b. Uptake on L-thyroxine 24%. Suppression scan, "hot" nodule persists but function of left lobe obliterated. c. Scan 1 year later reveals less function in left lobe than in a. d. Scan 2½ years after initial study reveals enlargement of "hot" nodule to 5 cm. and complete suppression of left lobe function. Patient still euthyroid.

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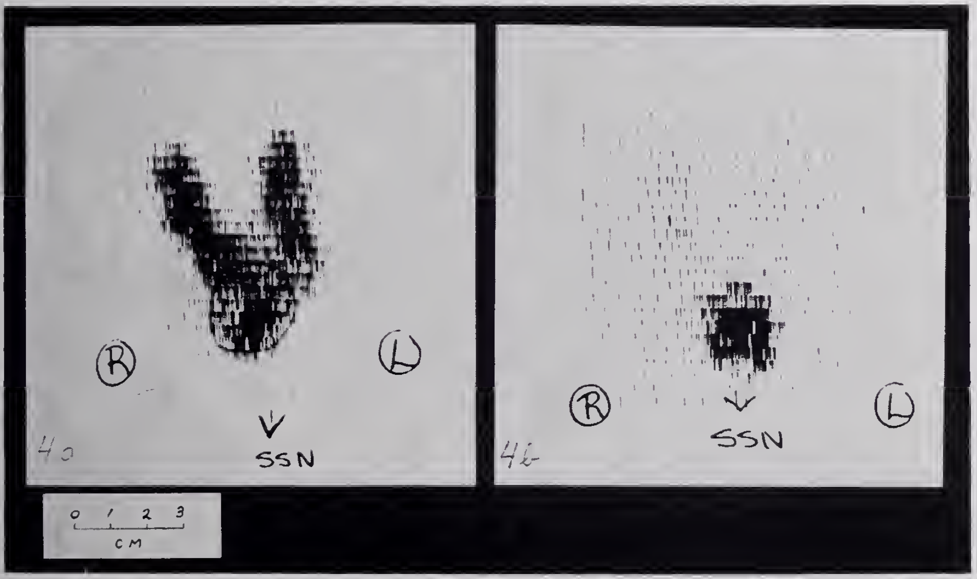

Figure 4: C. T., Euthyroid woman. a. 24-hour 131-1 uptake 27%. Two cm. "warm" nodule with function similar to that of the rest of the gland projects inferiorly from the isthmus. b. On L-thyroxine uptake suppressed to 7%. Suppression scan reveals all tracer confined to the nodule.

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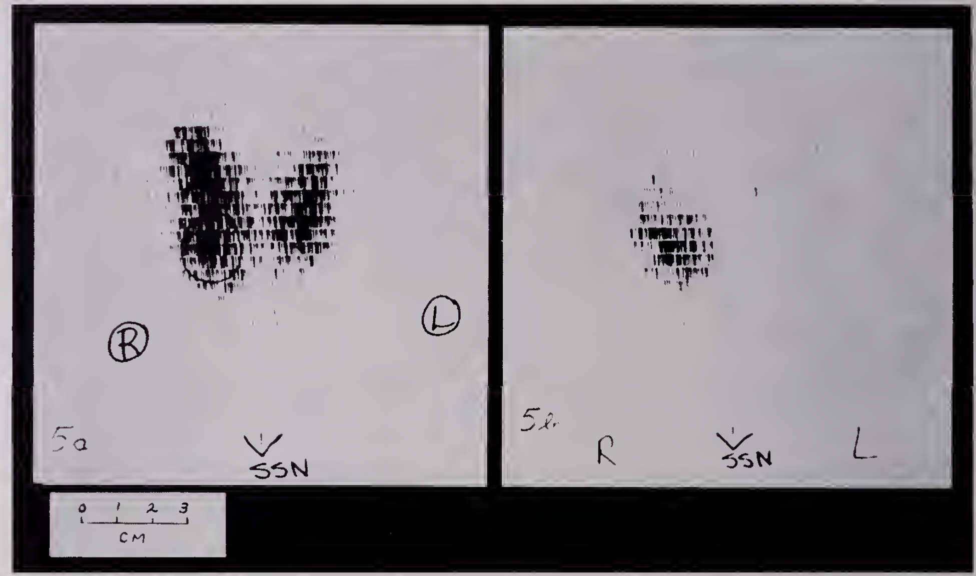

Figure 5: J. T., Euthyroid woman. a. 24-hour 131-1 uptake 24%. "Warm" nodule right lower pole identifiable only by markings on scan. b. On L-thyroxine uptake suppressed to 4%. Suppression scan reveals all tracer confined to the right lobe nodule.

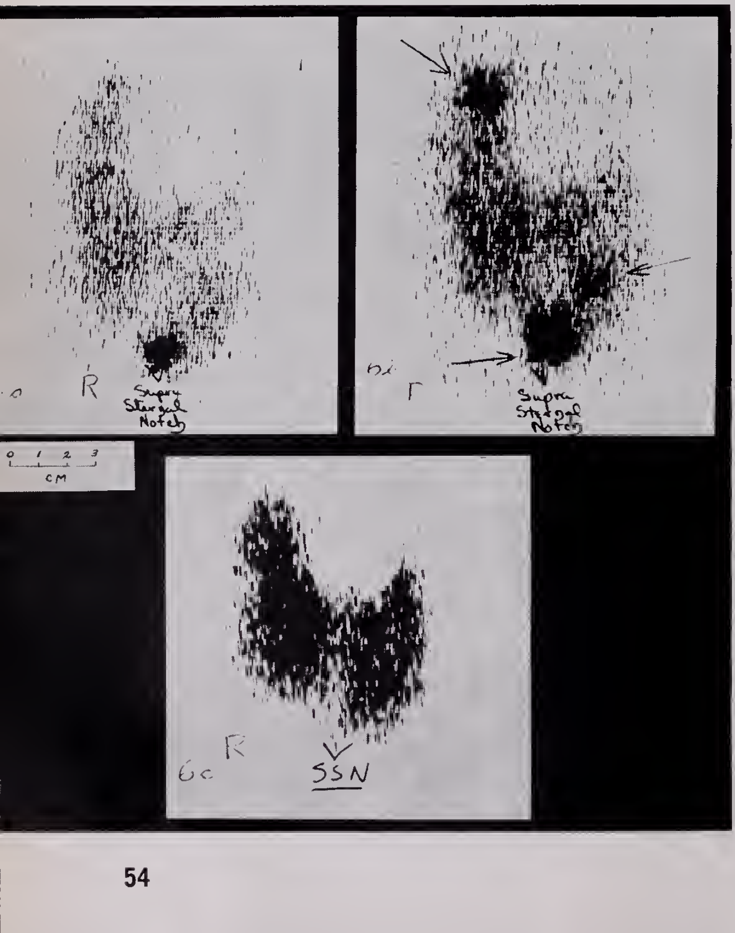

Figure 6: J. P., Woman with paroxysmal tacycardia. a. 24-hour uptake 41%. A large multinodular goiter with a 1.5 cm. "hot" nodule at the suprasternal notch is seen. b. On L-thyroxine the uptake suppressed to 22%. Suppression scan reveals persistent function diffusely with 3 areas of autonomous function (arrows) corresponding to palpable nodules. c. Three months after 30 mc. 131-1 the 24-hour 131-1 uptake is 27%. The scan reveals uniform function in a smaller gland.

Continued on Page 56

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(Figure 3) has been followed without therapy for almost 3 years. On the initial scan (3a) there is definite function in the contralateral lobe. This was obliterated on the suppression scan (3b). One and one-half years later (3c) there is relatively less contralateral activity in reference to background. Three years later (3d) the nodule has enlarged and contralateral activity is reduced to the level of background. The next 2 patients (Figures 4-5) have progressively smaller and less functional nodules with correspondingly less suppression of extranodular function on preliminary scan. Suppression scan confirms autonomous function in all instances. Patient J. P. (Figure 6) is an unusual example of multiple occult autonomously functioning nodules revealed by suppression scanning.

Discussion

All autonomous "hot" nodules are not associated with hyperthyroidism.[8] It is accepted that all "hot" nodules are not autonomous.[2] Now it must be emphasized that all autonomous nodules are not "hot." In fact, it is possible for an autonomous nodule to present on preliminary scan with function less than that of the extranodular thyroid tissue.[9] The incidence of autonomous nodules reported in this series is in no way comparable to the previously reported incidence of "hot" and/or "warm" nodules. In previous papers confirmatory studies for autonomous function were limited to "hot" nodules or, more often, entirely neglected. Comparative data on the incidence of autonomous nodules is sorely needed. Our data supports a prediction by Myhill, et al,[10] that very few functional ("warm") nodules are autonomous.

When the hormonal secretion of an autonomous nodule is insufficient to cause suppression of extranodular tissue ("warm" autonomous nodules) and there is relatively uniform 131-1 concentration throughout the scan, one cannot conclude after inspection of a preliminary scan that the activity, in the area in which the nodule localizes, arises from 131-1 concentrated by that nodule. The nodule may be totally nonfunctional and the activity observed could be arising from normal tissue in front of or behind the nodule. The appearance of the scan may not even indicate the presence of a nodule. Suppression scanning is necessary to confirm autonomous function in these "warm" nodules as first shown by Gorowski and Chomicki.[6]

It is of interest that the secretory activity need not correlate with the gross size of the nodule. Some large nodules produce less thyroid hormone than smaller nodules. This may relate to inherent differences in functional activity per unit of tissue mass, or may reflect the frequent observation that large portions of sizeable autonomous nodules may be nonfunctioning degenerated tissue.

Although "warm" autonomous nodules, in our experience, are uniformly asymptomatic, it is important for the clinician to consider the possibility of the existence of occult autonomous function for at least three reasons:

1. Current emphasis on the use of thyroid hormone for the treatment of goiter[11] may lead the unwary physician to precipitate an hyperthyroid state in a patient with nodular goiter and unsuspected autonomous function. The persistent secretion of the autonomous nodule will provide additional thyroid hormone to that administered orally.
2. Autonomous nodules, although asymptomatic when diagnosed, later may cause hyperthyroidism and/or cardiac arrhythmia. Knowledge of the existence of such a nodule will alert the physician to these possibilities.
3. When malignancy is suspected the demonstration of autonomous function will help to allay that concern.

The usefulness of scanning in the preoperative evaluation of thyroid nodules has gained wide acceptance.[12-18] Still there are those who consider scanning "disappointing,"[19] of "limited help,"[20] to provide only "negative information,"[21] and not "absolutely reliable."[22] In a recent paper published from Selenkow's laboratory, outlining a practical approach to the selection of nodular goiter patients for surgery, scanning was not even mentioned.[23]

Those who expected scanning to solve the clinical dilemma of which thyroid nodules should be excised have been disappointed. Nevertheless, scanning thyroid nodules can provide valuable data. Although there is general agreement that cancer usually presents as a "cold" nodule, all "cold" nodules are not malignant. Further evaluation must be clinically based. An hyperfunctional primary thyroid cancer has never been reported, and "hot" nodules are rarely associated with inci-

Continued on Page 65

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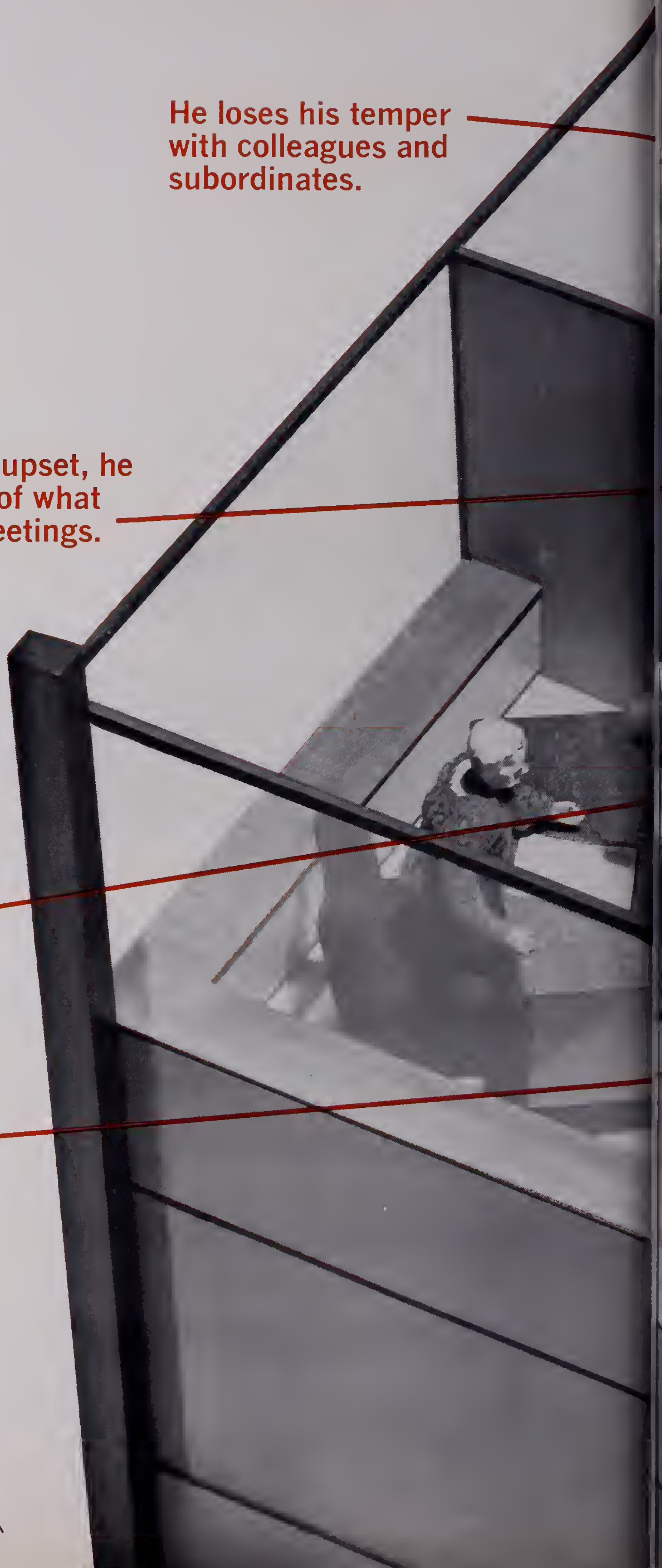

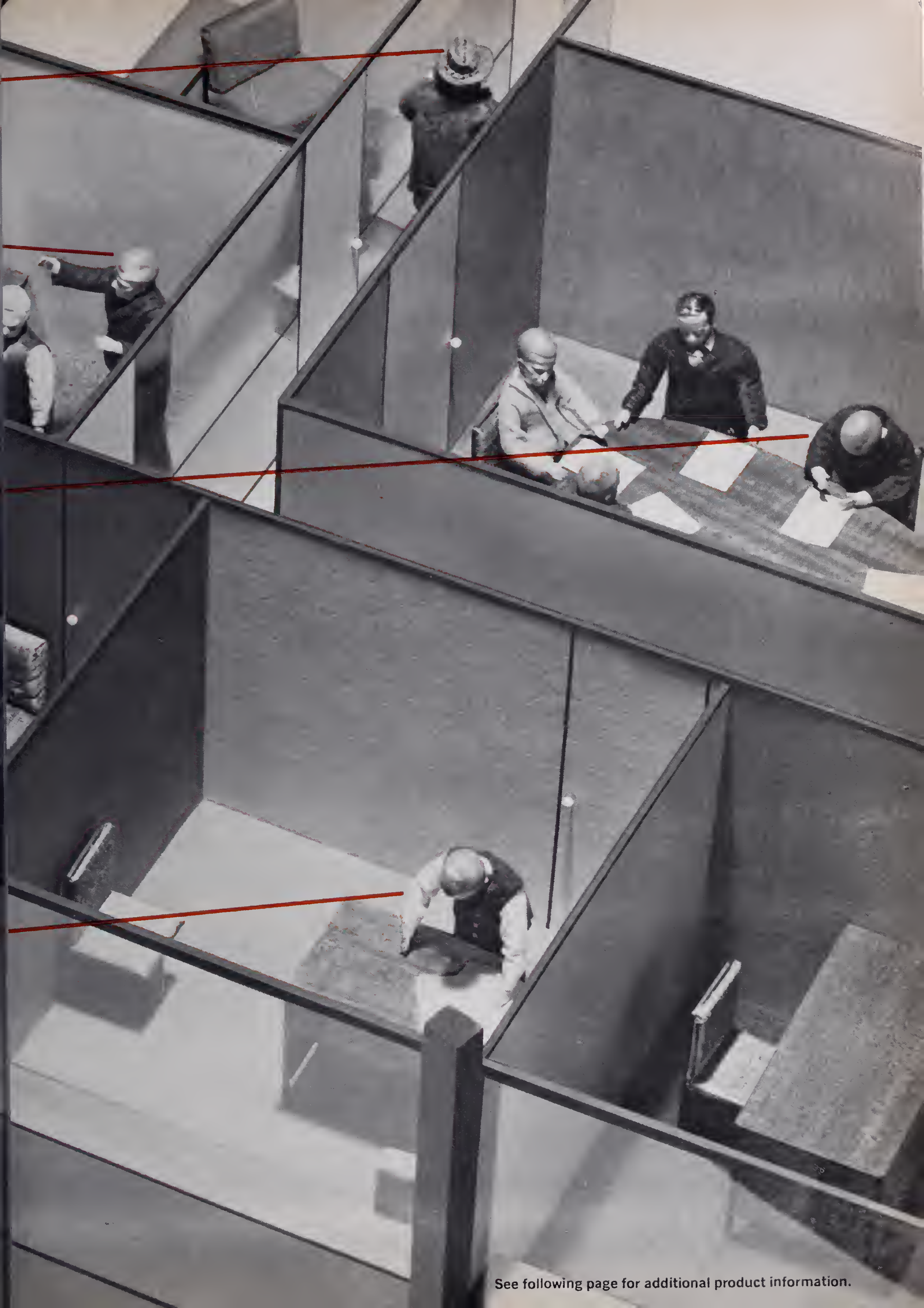

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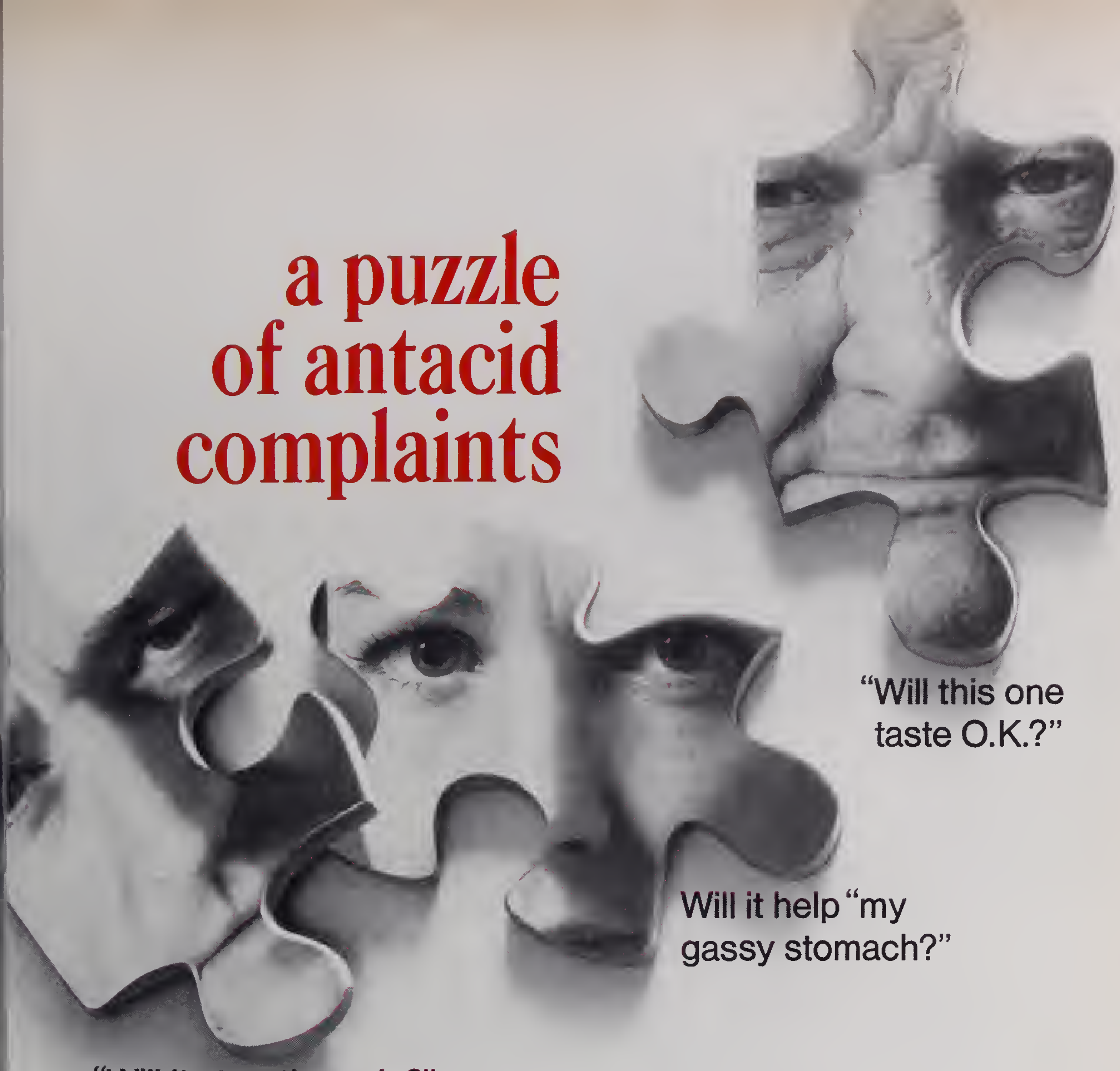
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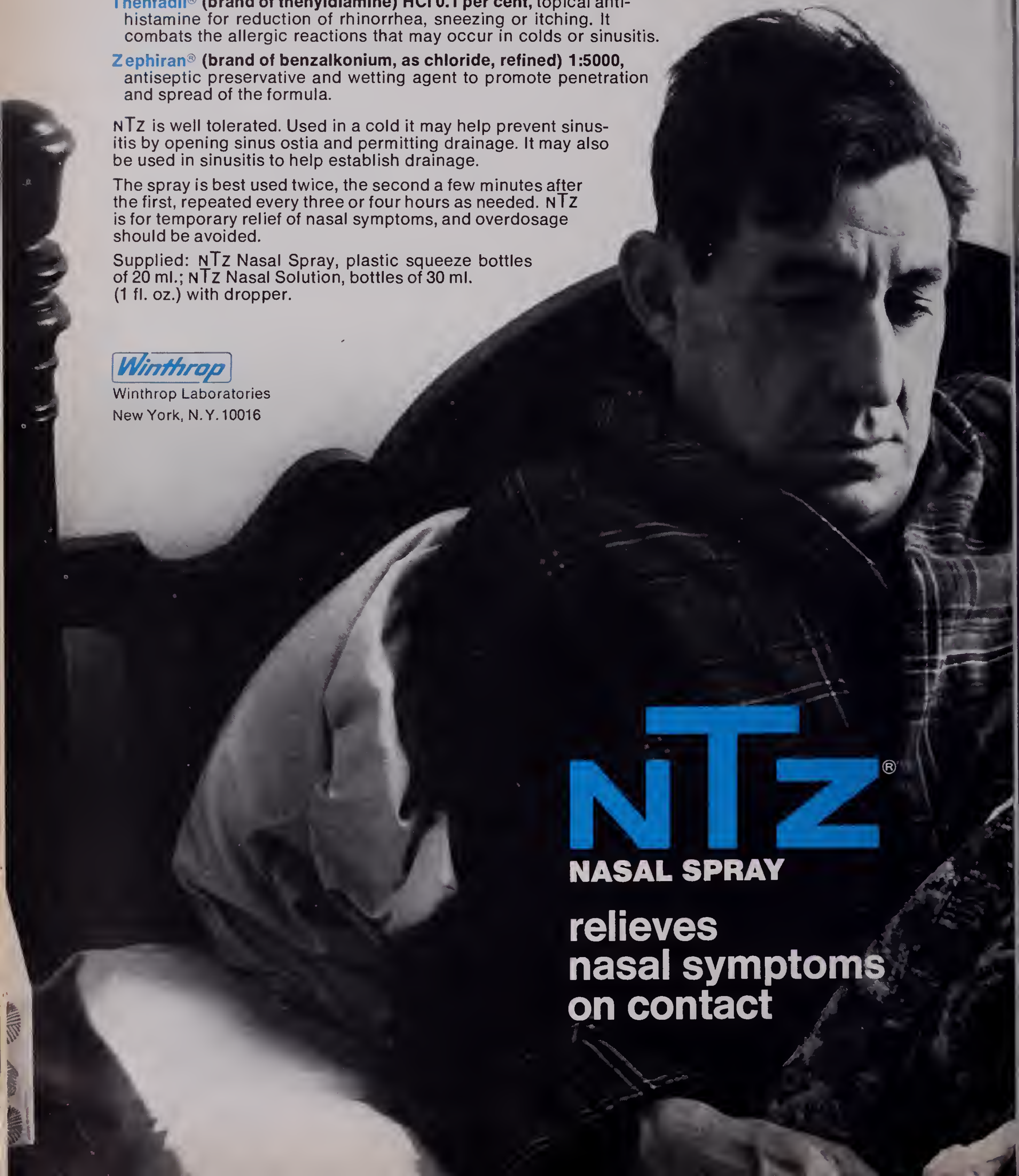

dental thyroid cancer.[2] Therefore, "hot" nodules are generally considered benign.

"Warm" nodules pose a more complex problem. As already noted, one cannot conclude that activity recorded in the area of the scan in which a "warm" nodule has ben localized actually arises from that nodule rather than adjacent normal tissue. It has been suggested repeatedly that "warm" nodules be given a trial of thyroid hormone treatment and those failing to regress should be removed.[12, 13, 17, 18, 22] However, two basically different types of thyroid nodules which may appear to be "warm" on scanning may not respond to thyroid hormone administrations:

1. Nonfunctional nodules, malignant or otherwise. In these cases the recorded activity actually arises from adjacent normal tissue.
2. Autonomous "warm" nodules whose function is independent of TSH.

Since an autonomously functioning thyroid cancer is yet to be demonstrated there would seem to be no need routinely to remove autonomous thyroid nodules. Of our series of 37 patients with confirmed autonomously functioning nodules, 10 had surgery. None had thyroid cancer. The employment of a suppression scan in the evaluation of "warm" nodules should thus extend the usefulness of both thyroid scanning and thyroid hormone administration as screening measures for malignancy.

Much remains to be learned about autonomous nodules. Of particular interest is the manner in which toxic autonomous nodules arise. Sheline and McCormack suggest that TSH dependent "hot" nodules may "escape from pituitary control" to give rise to toxic autonomous "hot" nodules.[8] In our opinion this concept assigns disproportionate significance to the simple physical phenomenon of iodine concentration. For a nodule to be "hot" on scanning requires only that extranodular tissue concentrate less tracer than the nodule. This may result from extranodular inflammatory disease, degeneration, agenesis or even surgical excision. Since "hot" TSH dependent nodules can arise as a result of such diverse pathological processes it seems inappropriate to consider increased iodine concentration per se as evidence for a fundamental relationship between all "hot" nodules. We believe that the similarity in physiology of nodules with varying degrees of autonomous function is a more acceptable basis upon which to predicate such a fundamental relationship.

Perusal of our data suggests not only that autonomous nodules of varying degrees of function may be related but also that toxic autonomous nodules may arise from autonomous nodules with lesser degrees of function. In support of this concept are the following observations:

1. Autonomous nodules with greater degrees of function generally were larger.
2. Larger and more functional autonomous nodules had a tendency to occur in older patients.
3. In a single patient it has been shown that over a period of 3 years an autonomous nodule enlarged and increased in function. Hence the spectrum of autonomous function here reported would seem to represent a recapitulation of the events in the development of a toxic autonomous nodule.

The failure of others to have observed the sequential changes in the development of toxic autonomous nodules is undoubtedly related to the following considerations:

1. Changes in the functional activity of autonomous nodules occur very slowly. A number of our patients have been followed for up to 4 years without discernible change in function.
2. Definitive therapy has generally been advised for solitary nodules in the past, thus eliminating the possibility of follow-up.
3. Methods to confirm autonomous function have only recently been reported and have not been widely employed.
4. In addition to progressive increase in function autonomous nodules may also undergo degeneration.

More conclusive data on the natural history of autonomous nodules will only be provided by a long-term study requiring the cooperation of all those who deal with nodular goiters.

Summary

Evaluation of 3088 referred, private thyroid patients showed that among 424 with discrete nodules, 161 patients had either "warm" or "hot" nodules. Confirmatory data, including suppression scanning, from 77 of these 161 patients revealed autonomous function in 37, or 48% of "warm"

and "hot" nodules, and at least 9% of all nodules. Scanning provided pictorial confirmation of autonomous function in nodules ranging from large, "hot" with hyperthyroidism, to occult, "warm" and asymptomatic. Asymptomatic autonomous nodules were observed without treatment, and provided data supporting the concept that autonomous "hot" nodules producing hyperthyroidism evolve from autonomous nodules with lesser degrees of function.

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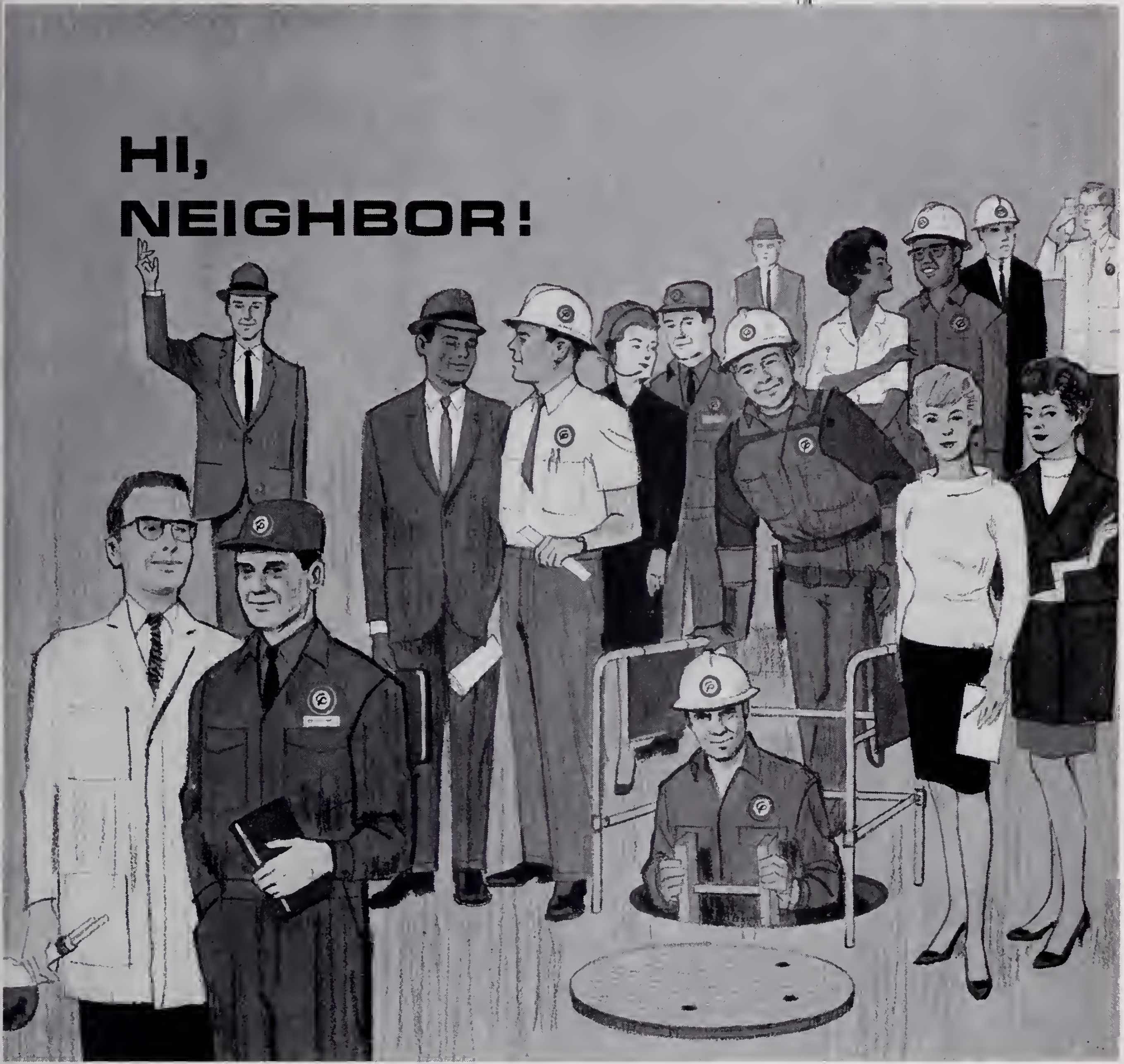

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Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

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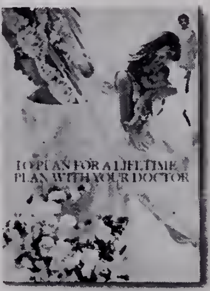

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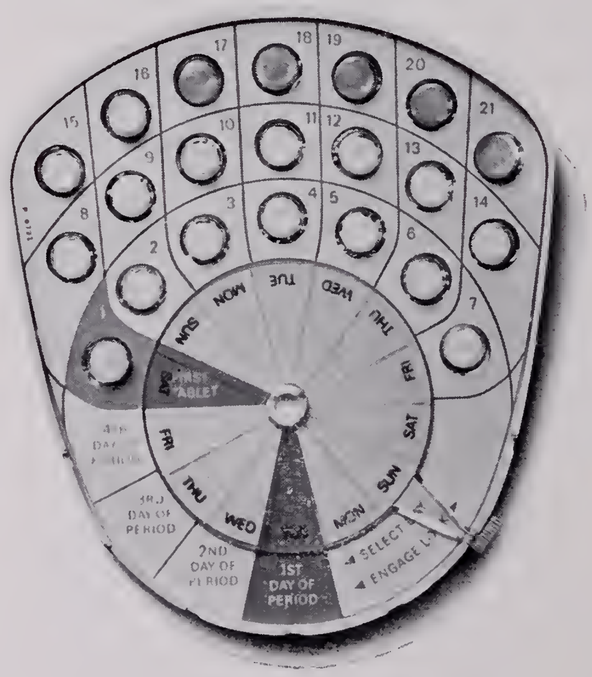

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What is Current Thrust of MSMS In Ethics, Discipline, Standards?

Where does MSMS stand on matters of ethics, discipline, professional qualifications, standards and morals?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS.

The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed the November issue are invited to go back and read it. The November article promised to print parts of the "Where We Stand" publication in future issues.

The first two subjects were reprinted in the December issue and other material will follow.

Discussion

Independent Judiciary Judicial Commission

MSMS established an independent judiciary, as it were, when it altered its bylaws to form the Judicial Commission. It did so because it wanted to place in one body the responsibility for the ethics, discipline, standard (of conduct), and morals of the profession.

Ethical Relations with Osteopaths

The Judicial Commission has felt its way slowly as behooves a deliberative body. It has approached the osteopathic issue from the standpoint of ethical relationships. It has met with the State Board of Registration in Medicine to develop means of solving mutual problems. It has considered numerous matters raised from within the Society.
The Judicial Commission has a long road ahead.

Clarification of Moral Principles, Customs, Usage

It must develop ways of clarifying:

1. Moral principles or practices;
2. Customs and usages of the profession;
3. Sound matters of policy not necessarily involving issues of morality in medical practice.

The last is necessary because sometimes the Judicial Commission might well base its decisions of unethicalness on conduct which fails to conform to custom and usages as reflected in MSMS policy. For example: Methods of charging for services if work is performed under contract with a hospital might give rise to disciplinary proceedings. Another example: The determination of whether a patient has the right to die is a question related to professional morals which has religious overtones which need the advice of the Medicine and Religious Committee and might require a philosopher's thinking as well. Yet both of these problems might fall within the responsibility of the Judicial Commission.

Advertising

Of late, considerable license has been taken by doctors who in an earlier day would have been found guilty of "advertising." This needs clarification in the light of modern communication media usage.

Disciplinary Measures

Disciplinary measures have never been spelled out on the state level and understood by the membership. This, too, could challenge the thinking of the Judicial Commission.

Joint Commission on Accreditation

The Joint Commission on Accreditation has served as a force to maintain standards. MSMS needs closer liaison with this Commission in order to understand its true function and properly interpret its decisions as being in the interest of the public and the profession. Due to the changing nature of the relationships of doctors with hospitals, it is a good guess that the Joint Commission's work will have a great deal to do with the practice of medicine in hospitals, with many aspects involving ethics and professional conduct.

Legal Counsel

Prior to the action establishing the Judicial Commission, the ethical rulings of the MSMS had been based upon the legal interpretations made by its General Counsel, who invariably indicated that his opinion was based solely upon the legalities involved and not upon the moral or ethical overtones.

Professionalism

Conclusion: This subject area which was carefully avoided by the MSMS for nearly twenty years is in need of systematic exploration. To do so will require not only legal but religious, philosophical, and medical research plus opinion sampling. This last line of defense of profes-

Continued on Page 74

...flexibility to meet new requirements

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sionalism can remain impregnable only if it is based on custom *plus reason,* with due recognition of the legalities involved.

Questions

Judicial Commission	A. Should there be a system providing for the continuous publishing of guidelines on ethics as issued by the AMA Judicial Council and the MSMS Judicial Commission?
Medicine and Religion Moral Responsibilities	B. Should the Judicial Commission be asked to inaugurate (perhaps in cooperation with the Medicine and Religion Committee) an exhaustive study of the "nature and scope of new moral responsibilities of the medical profession" caused by rapidly advancing scientific and engineering knowledge, increasing population, e.g.
DNA Altering	1. Moral questions involved in altering the DNA pattern, such as changing of personality, physical attributes, etc.?
Population Control	2. Moral questions involved in population control?
Limited Supply	3. Moral questions involved in limited supply of lifesaving machinery and facilities?
Artificial Insemination	4. Moral questions involved in artificial insemination using frozen sperm?
Abortion	5. Moral questions involved in abortion?

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Human Relations - The Key

BY DON MARSHALL, M.D.
COUNCILOR, KALAMAZOO

It is comforting and reassuring to be informed once more that most patients like their doctor and their hospital, and are even more favorable to the doctor than the hospital. Such a report has just been published *based on a careful interview of 124 patients. They were accurately representative of the population of north Florida, hospitalized for a typical variety of medical illnesses.

Their confidentially expressed attitudes toward doctor and hospital were not correlated to age, sex, race, marital status, religion, occupation, education, social status, or size of home community.

WHY NEED WE BE concerned with the attitude toward us of our patients and of the public generally?

It is important that our patients understand what we are trying to do for them; it is important that the public understand the problems our profession and the health team and — yes — our patients too, face. If our profession is to be heard, if it is to be a leader in health care progress, it must have the respect and confidence of its audience, both patients and general public.

What are these problems?

There are many that doctor and patient face daily. The health team is shorthanded; there aren't enough doctors, nurses and others to meet demands and needs. Costs are rising precipitously. House calls are in some ways inefficient but may be necessary, and home care has its good points as well as economies. Specialization continues to increase, fragmenting the patient and his care.

EMERGENCY ROOMS ARE substituting for evening office hours. Patients wonder whether the best paid profession is earning its fees, so mediation cases increase. Results of care have improved so much that the inevitable failure leads to suits for malpractice or breach of contract.

These problems aren't new, but have been increasing in the last decade. Our attempts to solve them will be far easier if we have patients and public who are understanding and trusting of our efforts. Yes, the attitude of patients and public *is* of real importance to us.

There is today a widespread surge in planning, in an effort to make more efficient use of existing health facilities, to raise levels of health care and distribution. The medical profession could be a leader in the inevitable changes going on, if it will exert itself sufficiently. If we don't fill the vacuum, there are sociologists and bureaucrats eager to show the way. If we are to lead, the confidence of the public will be of inestimable help.

WHAT CHANGES ARE going on in the medical arena? Group practice is spreading, medical care is growing more urban and more hospital based. Specialization of the whole health team increases, with more and more being performed by technicians and aides, even by computers. Techniques and equipment grow more sophisticated and expensive.

Prevention of disease and maintenance of optimum health is being emphasized. There are increasing demands that the physician keep abreast, even that he be periodically re-examined and relicensed.

We must guard against self satisfaction because most of 124 patients in a Florida medical wing say they liked their doctor. We hope it is true in every state. We must, each of us, work to hold the respect and understanding of every patient, for in that human relationship lies our most important PR effort. Our public image **IS** important.

---

* Medical Inpatients' Attitudes Toward Physicians and Hospitalization: J. Florida M.A./pp 10561058, November 1967.

Photo professionally posed.

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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—Almost 6 of every 10 public school buildings have no Negro pupils at all.

—Nearly 3 out of every 4 Negro students in Michigan attend predominantly Negro schools, those with 60 per cent or more Negro pupils.

—Almost 3 out of every 5 white pupils attend schools where there are no Negro pupils.

—Some 3.6 per cent of public school buildings have student bodies of 95 or more per cent Negro pupils.

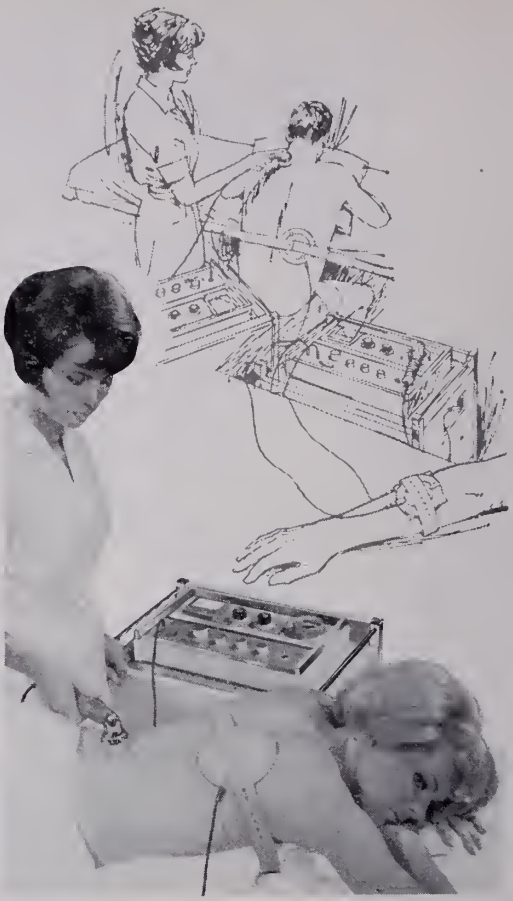
These are some of the highlights of Michigan's first public school racial census reported to the Michigan State Board of Education.

The first report was based on questionnaires returned by 3,374 principals and 63,469 classroom teachers of 1.8 million public school pupils.

The survey, State Board officials report, also found that 4 out of 10 public schools—40 per cent—have some outside non-neighborhood pupils in their classes, but that only 1.2 per cent have openly moved students around to achieve racial balance.

For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.



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Doctors may be interested in reading a publication, Dialogue on Adolescence, *published by the United States Children's Bureau. The sketch with this feature article is from the publication. The booklet may be obtained by writing to the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402. Price 30 cents.*

Inner-City Youths Comment on Alcohol, Drugs, Sex Education

What recommendations would be made by inner-city youths about drugs, alcohol, LSD, and sex education?

Physicians are interested in the eight recommendations offered by the Michigan Youth Commission's "Open-Ended Youth Conference." Eighty inner-city boys and girls participated.

Drinking

During the recent conference, six discussion groups decided to discuss drugs, alcohol and LSD. Conference sponsors reported that "drinking received a great deal of attention with four specific recommendations." They were:

"1. Since most teen-agers do drink before they are 21, consideration should be given to lowering the age for drinking, or abolishing the law entirely. If this were done it might be that youth wouldn't feel the need to drink so much just to show that they are adults.

"2. Youth should receive more information about the effects of drinking.

"3. There should be more supervised entertainment.

"4. If the present laws on drinking are to be kept, they should be strictly enforced."

Narcotics

The Conference leaders also reported that "while the youth felt that there was a large amount of drug pushing around the schools, especially in certain neighborhoods, and that it was therefore a serious problem, they had few specific recommendations."

Following are the specific suggestions:

"1. Youth should be educated as to the use and effects of drugs and the danger of becoming an addict.

"2. The possibility of legalizing marijuana should be considered but this should be separated from other harmful drugs, like heroin, etc.

"3. Places where school youth get together should be checked to uncover dope pushers.

"4. Treatment should be offered to drug addicts.

Sex Education

"Sex education was considered by the inner-city youths as of great importance," the Conference sponsors observed. The boys and girls presented four recommendations:

"1. Sex education should be taught in schools, beginning in the sixth grade. In teaching this subject, there should be an explanation of how the biological, psychological and sociological factors are all inter-related.

"2. Birth control information should be taught some time in high school.

"3. There should be classes for parents to help them understand the best approaches to use in explaining the problems of sex to their children."

Comments Under Study

The conference recommendations on 15 different subjects have been presented to the Governor's office by the Michigan Youth Commission and representatives of the inner-city conference.

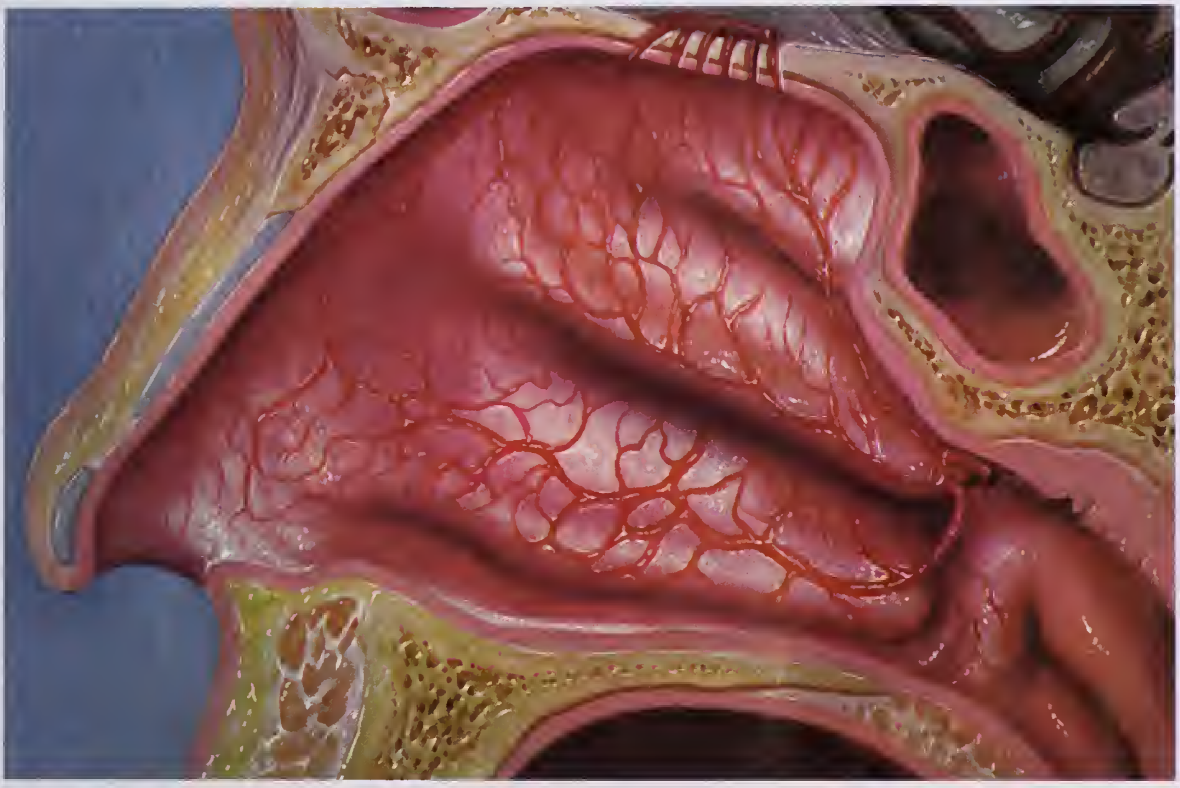
The recommendations now are under study by the MYC and its Youth Advisory Council for possible action projects.

The Youth Commission includes Irving Posner, M.D., Detroit; Eleanor Skufis, M.D., Adrian; Robert Heavenrich, M.D., Saginaw; and Herbert A. Auer of the MSMS executive staff.

winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.



this issue: the cold in pregnancy...

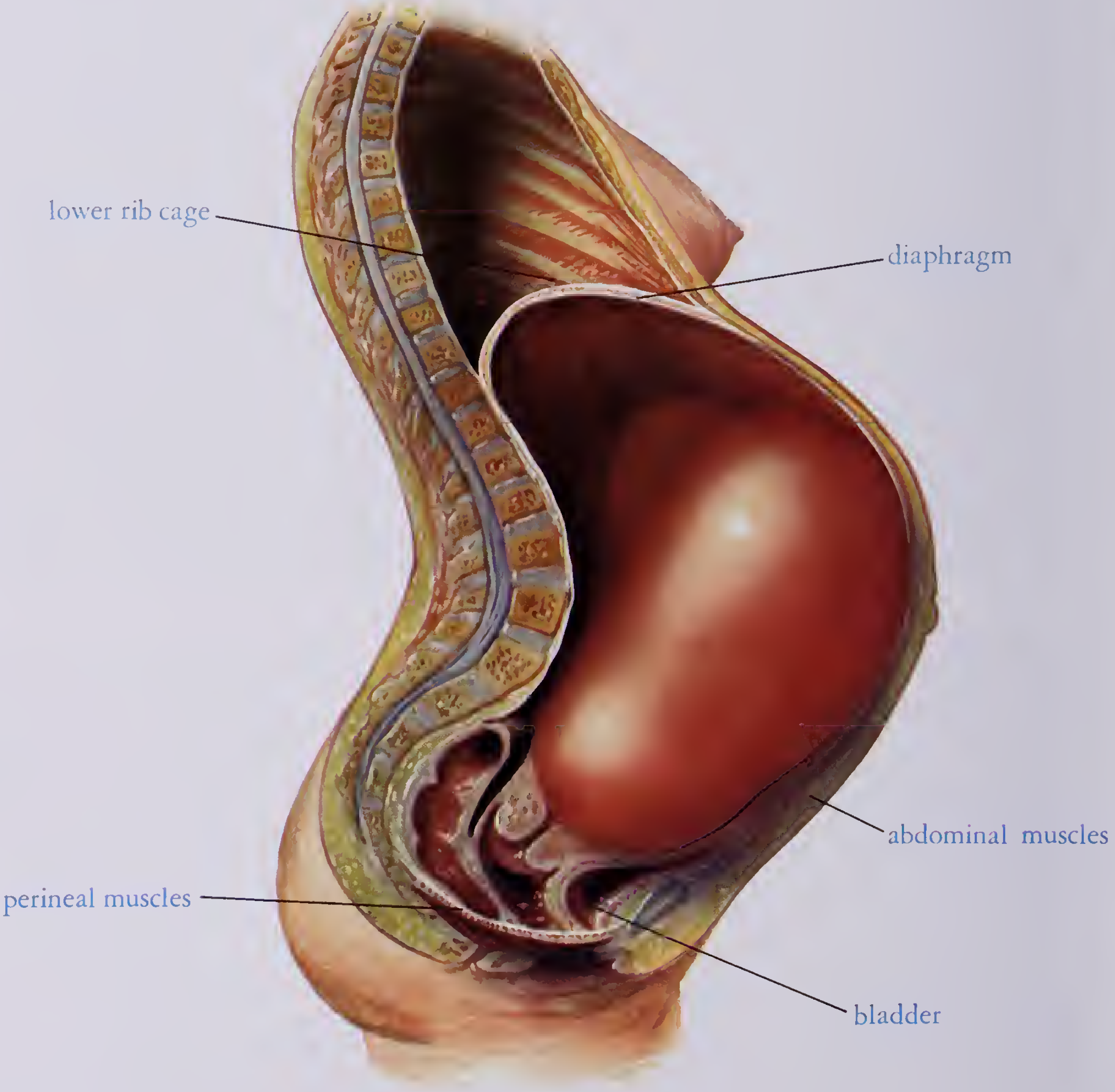
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

the most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.

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Tell her to get
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Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
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MICHIGAN MEDICINE
DEADLINE FOR THE BREAKING NEWS WAS DECEMBER 26, 1967

Many Outstanding Authorities To Address 1968 Maternal, Perinatal Welfare Conference

"Practically all the speakers at our Seventh Annual Conference on Maternal and Perinatal Welfare this year are from outstate," announces Jack W. Thompson, M.D., of Flint, conference chairman.

"Physicians will especially be interested in the talk by John Gorman, M.D., Director of the Blood Bank at the Presbyterian Hospital in New York," Doctor Thompson said. "For the past few years he has been doing experimental work in the development and use of antibodies for the treatment of Hemolytic disease in newborn babies."

Doctor Gorman will speak at 10:30 a.m. on Wednesday, March 27, the second day of the conference. The MSMS Conference will open at 1:15 p.m. Tuesday, March 26, at the Pick-Durant Hotel in Flint, and close at noon on Wednesday.

The Clara Elizabeth Fund of Flint is cooperating again in the sponsorship of the conference.

Other talks of general interest to all physicians will be a discussion of "New Abortion Laws," by E. Stewart Taylor, M.D., from the department of Obstetrics-Gynecology at the University of Colorado Medical Center in Denver, and a discussion of "Infertility," by Herbert W. Horne, Jr., M.D., an internationally-known authority on infertility from Brookline, Massachusetts.

Since Colorado is one of the states which has liberalized its abortion laws, Doctor Taylor's comments will be valuable to Michigan physicians in light of the proposed liberalization here.

All MSMS members have received a complete program listing all the talks at the 1968 Michigan Conference on Maternal and Perinatal Welfare. There is no registration fee.

"Physicians who cannot come for the complete two days should feel free to drop in for any part of the program they have a special interest in," Doctor Thompson adds.

Heart, Cancer, Stroke Programs Moving in 49 Regions in Nation

"The imagination, knowledge, and energy to operate Heart, Cancer and Stroke Medical Programs will come from the local level."

So declared President Lyndon B. Johnson in a message to Congress with the first report on the Regional Medical Program. The President reported that more than 1,600 local health leaders — physicians, officials of medical centers, hospital administrators, teachers, and other health workers — are active as members of regional advisory groups.

In 49 regions (with all of Michigan as one region) alliances have been formed between medical schools, hospitals, and local doctors; 24 million dollars in Federal planning money has been awarded. At present the 49 regions cover 91 percent of the nation's population.

In five regions, cooperative medical programs are already operating with the help of 7.3 million dollars in Federal grants.

The Michigan Association for Regional Medical Programs (MARMP) received $1,285,155 on June 1, 1967 for its headquarters and for projects of the three medical schools and the state health department.

GEORGE CURRY, M.D., OF FLINT, DIES

George J. Curry, M.D., prominent Flint orthopedic surgeon, died November 29. He was 76.

Graduated from the University of Michigan Medical School in 1915, in 1920, Doctor Curry began his practice in Flint which he continued until his retirement to Florida last year.

He was affiliated with Hurley Hospital, Flint, where he was chairman of the committee on graduate training in surgery and director of the Cancer Registry.

Doctor Curry originated the first surgical training program in Flint and founded the section for trauma surgery at Hurley Hospital. In 1958 he was chosen to give the annual trauma lecture at the Clinical Congress of the American College of Surgeons. He received the "1960 Surgeons Award" of the National Safety Council for his studies on transporting the injured.

A past regent of the American College of Surgeons, he served on the board of governors of that organization in 1947 and was a past president of the Michigan chapter. He was a founding member and past president of the Flint Academy of Surgeons and a Life Member of the Michigan State Medical Society. Other professional memberships included the Central Surgical Association and the American Association for the Surgery of Trauma.

Doctor Curry was a member of the Flint Civil Service Commission for six years and was once medical director for the Flint Civil Defense Council.

TOWSLEY OUTLINES 1968 MUF PLANS

Plans for 1968 were outlined at the Michigan United Fund Campaign achievement luncheon at Kellogg Center December 4 by Harry A. Towsley, M.D., the MUF President.

The fall campaign topped all MUF drives.

RE-ELECTED SPEAKER FOR MED. ASSISTANTS

The American Association of Medical Assistants at its recent convention in Los Angeles re-elected Betty Lou Willey, Port Huron, as speaker of its House of Delegates.

Betty is a past president of the Michigan State Medical Assistants Society.

SPEAKS ON SEX EDUCATION

"Sex Education for Teen-Agers" was the subject of the talk delivered by John R. G. Gosling, M.D., associate professor of obstetrics and gynecology at the University of Michigan, at the December meeting of the Bay, Arenac, Iosco Counties Medical Society.

PRE-MED STUDENTS HOSTED BY COUNTY MEDICAL SOCIETY

Members of the Gratiot-Isabella-Clare County Medical Society are pleased with the success of their recent dinner for pre-medical students of Alma College and Central Michigan University.

Andrew D. Hunt, Jr., M.D., Dean of the Michigan State University College of Human Medicine, addressed the group which included 29 junior and senior premedical students, several wives, MSMS Councilor Aaron C. Stander, M.D., Saginaw, and area physicians.

After the meeting, interested students adjourned to the home of one of the doctors for informal discussions.

An informal moment between Banquet Speaker Franklin V. Wade, M.D., (right) and Joseph L. Posch, M.D., Conference Chairman of the Trauma symposium.

WADE DESCRIBES VIETNAM WORK

"About 70% of our surgery was directly related to war injury," said Franklin V. Wade, M.D., speaking of his work in Vietnam in a luncheon speech during the second day of the December 6 and 7 Trauma Symposium in Detroit.

Doctor Wade worked with Vietnamese civilians for two months this past summer at one of the provincial hospitals in the Mekong Delta.

"We would begin each day by making the rounds in the hospital and looking at the casualties which had come in during the night," the Flint physician said. "In the afternoon I hoped to get at some elective cases, thyroid conditions and some huge tumors, but it was a rare day I could do so because the casualties just keep coming in. I generally did a major amputation each day. Reconstruction is practically impossible because of the sanitary conditions."

"One of the most vicious instruments is a foot mine which the VC plant in travelled places. Usually made out of an old beer can," he said, "It causes a great deal of injury among the people."

The Mekong Delta, according to Doctor Wade, has 6,000,000 people. The doctor-patient ratio for 1966 in that area is 1-32,000, and 1.4 hospital beds per 1000 people.

"As far as work with diseases go," Doctor Wade concluded, "You see practically everything which afflicts mankind: TB, parasites, typhoid, cholera, and all sorts of infections."

Babcock Predicts More Suits Charging Hospital Negligence

Hospitals and attending physicians can look forward to more frequent lawsuits alleging hospital negligence.

This prediction was made recently by Kenneth B. Babcock, M.D., a hospital consultant and former director of the Joint Commission on Accreditation of Hospitals.

Speaking at a recent Institute of Continuing Legal Education program on hospital liability law at The University of Michigan, Doctor Babcock said it is the responsibility of a hospital medical staff to "prevent incapable and unworthy practitioners from obtaining the privileges of the hospital."

"In my considered opinion," Doctor Babcock continued "the weakest single stone in the structure of hospital operation today is due to the failure of medical staffs to accept, and to discharge, these responsibilities."

Doctor Babcock called for chiefs of staff to be appointed by hospital trustees.

Most chiefs of staff are elected by the staff with the concurrence of the board. But the chief does not, at present, represent the medical staff. "He derives his authority from the board and is accountable to the board for any actions of the medical staff," he said. "Few medical staffs realize this."

Doctor Babcock further predicted a "greater usage of informed consent." With such a consent form, physicians will be more free to treat their patients especially during emergencies and operations.

HONOR EDMORE DOCTOR

Myron G. Becker, M.D., celebrating his 50th year in practice, was honored for his service to the community of Edmore by a public reception on December 10. A committee, appointed by the Edmore Area Chamber of Commerce, made arrangements for the program.

National SAMA Convention Coming to Detroit in April

Plans are progressing on schedule for the Student American Medical Association national convention which will meet for the first time in its history in Detroit April 23-27.

The decision to hold the meeting in Detroit was basically "a tribute to Wayne State University during its Centennial year," according to Russell F. Staudacher, SAMA Executive Director.

At present about 70% of medical students throughout the U.S.A. are members of SAMA. Total registration for the convention is expected to reach 1500.

MSMS will assist the convention with a program grant of $500.

The national convention will begin on Tuesday, April 23, with a SAMA Council dinner in the evening. Awards banquet and presidential address will be on Thursday evening.

Grand Rapids M.D.s Tackle Medical Help To British Honduras

Three Grand Rapids physicians, at the invitation of George Price, premier of British Honduras, spent the week of December 10-17 in Belize, capital of the country, discussing the possibilities for increased medical assistance to British Honduras.

James Klomparens, M.D., Edward Jones, M.D. and Robert Burton, M.D. hope to establish a program under which Michigan physicians, on a rotating basis, will work on medical projects in British Honduras, Michigan's sister-country in the Partners of the Alliance.

"The country becomes independent in 1968," Doctor Burton said, "and many of the British doctors working on contract are expected to return to Great Britain. Perhaps we can work out a way to give some assistance."

Being inducted into the Michigan Health Council's Hall of Fame are E. Gifford Upjohn, M.D., board chairman of the Upjohn Company, Kalamazoo, left, and Emory W. Morris, M.D., center, president and managing director of the W. K. Kellogg Foundation. The awards were presented at a three-day institute by Harry A. Towsley, M.D., right, MHC president. Doctor Upjohn is the new president-elect of the Council.

MSMS Award Presented To Swan in Detroit

Seventy members of the Detroit Medical Society gathered with about 30 interns, residents and medical students from the Detroit area for an evening banquet, November 28, to honor Lionel F. Swan, M.D., for his work as president of the National Medical Association.

Doctor Swan received three awards at the banquet: A MSMS plaque presented by president-elect James J. Lightbody; a Detroit Medical Society plaque; and a parchment scroll from the City of Detroit, in light of the Common Council's proclamation of November 28 as Lionel F. Swan day. Doctor Swan had been unable to attend the 1967 Annual Session dinner dance to receive the MSMS National President's Award.

A featured speaker at the banquet was Waldo Cain, M.D., who will take over as president of the Detroit Medical Society in January. Also present was L. R. Swift, M.D., from Durham, North Carolina. Doctor Swift is chairman of the Talent Recruitment and Motivation Committee of the National Medical Association.

Pathologists Meet

Harry Oberman, M.D., Department of Pathology, University of Michigan, was discussant of a seminar on Tumors of the Breast at the meeting of the Michigan Society of Pathologists December 9, at the University of Michigan.

Problems of diagnosis, treatment and outcome of a wide variety of tumors of the breast were extensively discussed using fifteen different cases as examples. Doctor Oberman placed emphasis on careful differential diagnosis to offer the surgeon the best opportunity for proper treatment.

The Society will meet at Ford Hospital on February 10 for presentation of diagnostic procedures using enzymes.

UNIVERSITY HOSPITAL COSTS $30 MILLION EACH YEAR

It costs $30 million per year to run the 1,000-bed University Hospital at Ann Arbor, according to Ernest C. Laetz, the hospital's chief financial officer.

He said the entire sum, except for a psychiatric unit subsidy, is obtained from service fees charged to patients.

Cancer Foundation Hears Heustis

Albert E. Heustis, M.D., Executive Director of the Michigan Association for Regional Medical Programs, spoke at the Michigan Cancer Foundation's annual dinner meeting December 13, in Detroit.

Several awards were presented for outstanding service.

McCabe Outlines Shield's New Health Care Study

Michigan Blue Shield's national study on measurement and control of quality and efficiency of health care is being pursued vigorously "without preconceived goals or notions."

John C. McCabe, president of the Michigan plan, reported the study's progress in remarks prepared for delivery to the American Medical Association's recent national conference in Houston, Tex.

Mr. McCabe assured the AMA and its guests that Michigan is conducting "no culprit hunt" but is, rather, "criss-crossing the nation" to study existing care review mechanisms in other Blue Shield plans, in various government agencies, and in cooperation with studies under way at the University of Michigan and Yale, Brandeis, Johns Hopkins and Harvard.

The Michigan plan set aside $100,000 in June for the project, to be operated above and apart from standard quality and cost review. A team of medical and lay experts from the Blue Shield board of directors then established guidelines for the study. Staffing of the project began last month.

The result, Mr. McCabe emphasized, is intended to be a pattern which agencies throughout the United States can use to start health care and quality reviews, not a review itself.

Matters under examination are possible over and under use of facilities, cost and fee levels, regional socio-economic factors, profiles of treatment and a mass of matters impossible to explore until the new Blue Shield computer systems were established.

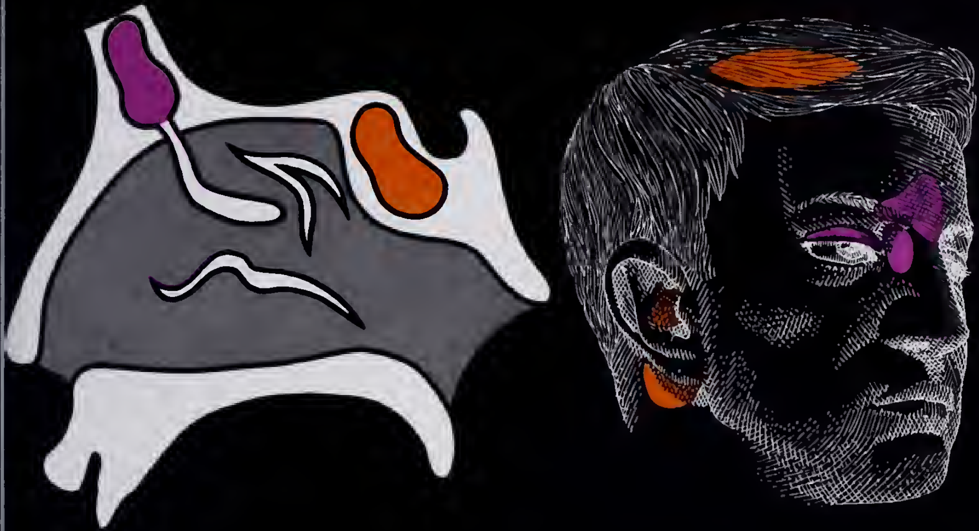
The review study "is not necessarily a dollar economy measure," Mr. McCabe said, because it "is possible we will find gaps in existing medical utilization which will be expensive to fill."

Even should some medical care abuses come to light, Mr. McCabe said, and thus disinter "some inevitable skeletons," the intent "is to give them quiet burial, not to rattle and brandish their bones."

Michigan Blue Shield is possibly best suited for the study, Mr. McCabe said, because of its responsibility in implementing the new automobile health care contracts nationally to Michigan standards and because of its role in regular business, which with Medicare and Medicaid involves service to about 65 per cent of the population. Michigan Blue Shield is building enormous reservoirs of information, Mr. McCabe said.

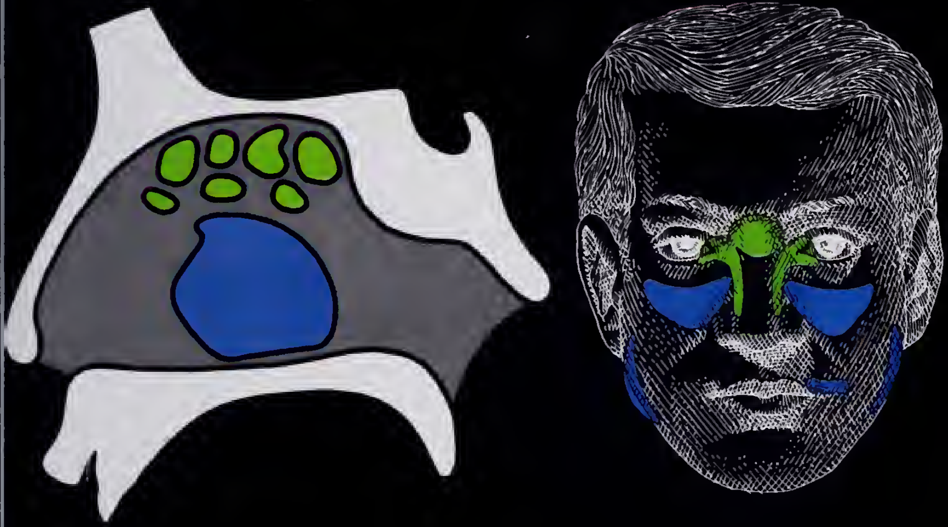
Blue Shield, Mr. McCabe said, "is the third party to the private physician-patient relationships in medicine, the only agency with the shared public and professional trust which a definitive study must have, the one with the records, data equipment, the know how needed for the job."

Sources of sinus headache

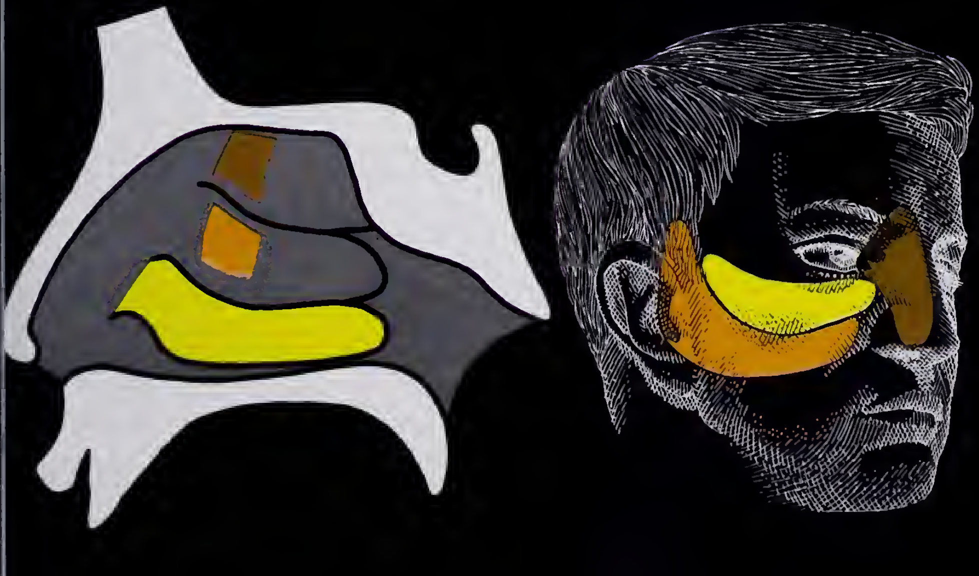


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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COMING EVENTS

YALE RESEARCHER TO DELIVER 1968 BEAUMONT LECTURE

BY PETER HOHEISEL
OF THE MSMS STAFF

A Yale physiologist who has stopped a raging bull in midcharge, changed a loving monkey mother to a rejecting one, and turned a normally reserved young woman into a flirt will deliver the 47th annual Beaumont Lecture at Wayne Medical Society headquarters on April 1, 1968 at 8:00 PM.

Jose' M. Delgado, M.D., professor of physiology at Yale, will speak on the "Effect of Brain Stimulation by Radio Receptors."

The lecture is open, free of charge, to all physicians at 8:00 PM. Cocktails and dinner begin at 6:30. Dinner charge is $5.25.

One of his most widely known experiments has been to implant tiny electrodes in the brain of a female rhesus monkey and, through radio signal manipulation, change the monkey from a loving, protective mother to one who rejects her nursling. Besides changing emotional responses in monkeys, Doctor Delgado's experiments have also heightened already existing emotions. For example a charge in the brain of a boss monkey sent him into a rage against an unfriendly male in the colony, but his feelings for his friends remained the same. "The details of his aggression and directions of his hostility were set by previous experience," explains Doctor Delgado.

Treatment of epileptics and violent mental patients has sometimes involved similar techniques. Doctor Delgado cites the case of an 11-year-old epileptic boy with uncontrollable seizures and destructive behavior who was calmed down in preparation for brain surgery through cerebral electric stimulus. The charge, however, did not alter his facial expression, intellectual level, or basic personality.

Emphasizing that he is not concerned to manipulate normal human behavior, Doctor Delgado commented "I don't want people to think I'm against motherhood. He sees his research into the physical and chemical basis of emotion and thought as a help in developing new ways of treating the mentally ill.

MEDISCENE

Jan. 19-20—16th Annual Symposium on Blood, McGregor Memorial Conference Center, Detroit

Jan. 24—Seventh Annual Thyroid Workshop, Wayne County Medical Society Headquarters, Detroit

Jan. 24—The Council, MSMS Headquarters, East Lansing

March 6—The Council, MSMS Headquarters, East Lansing

March 13-14—Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 26-27—Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 17—The Council, MSMS Headquarters, East Lansing

April 22-25—Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

Apr. 23-28—17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

May 1-8—Mental Health Week

May 8-10—Michigan Public Health Association, Inc., Annual Conference· Jack Tar Hotel, Lansing

May 10-11—Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 15—Annual Muscle Symposium Wayne County Medical Society, Detroit

May 18—Kresge Eye Institute Clinic Day, Detroit

May 18-19—Pediatric Clinic Days

June 5—The Council, MSMS Headquarters, East Lansing

July 18-20—The Council, Grand Hotel, Mackinac Island

Aug. 21—The Council, MSMS Headquarters, East Lansing

Nov. 11-15—American Public Health Association Annual Conference, Detroit

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.

Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.

Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.

In rare instances, transient cardia
arrhythmias have occurred in hype
thyroid patients and in patients receiving thyroid medication when
Tofrānil was added to the regimen
Imipramine may block the pharma
cologic activity of guanethidine ar
other related adrenergic neuron-blocking agents.

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present time in patients under 12
of age.

Adverse Reactions: Dryness of the
mouth, tachycardia, constipation,
turbances of accommodation, swe
ing, dizziness, weight gain, urinar
frequency or retention, nausea an
vomiting, peripheral neuritis, mild
parkinson-like syndrome, tremors
rare cases of falling in elderly patients, confusional states (with su
symptoms as hallucinations and d
orientation), activation of psychos
schizophrenics and agitation (incl

When a milestone in life is marred by depression...

Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

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Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

ypomanic and manic episodes)
may require dosage reduction
or addition of a tranquilizer or
orary discontinuation of the drug,
otiform seizures, orthostatic
ension and substantial blood
ure fall in hypertensive patients,
ra, transient jaundice, bone mar-
epression including agranulocy-
sensitization and skin rash
ding photosensitization, eosino-
, and mild withdrawal symptoms
dden discontinuation after pro-
d treatment with high doses.
sional hormonal effects (im-
ce, decreased libido, and estro-
effects) may be observed.
ine-like effects may be more
unced (e.g. paralytic ileus) in
ptible patients and in those
anticholinergic agents (includ-
ntiparkinsonism drugs).
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. daily, increased, if necessary,
to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

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THYROID WORKSHOP AT WSU SCHEDULED, JAN. 24

Wayne State University will hold its Seventh Annual Thyroid Workshop· January 24 at the headquarters of the Wayne County Medical Society. Visiting professors for the day-long program will be John Stanbury, M.D., Professor of Experimental Medicine at the Massachusetts Institute of Technology, who will present a paper on "The Goiter Problem," and Harry H. Towsley, M.D., Chairman of Post Graduate Medicine at the University of Michigan Medical School who will discuss "Goiter in Michigan."

Alexander J. Walt, M.D., Chairman of General Surgery and Assistant Dean at the WSU School of Medicine, will introduce the program at 10:00 a.m. Registration will open at 9:00 a.m.

General chairman of the workshop is Myer Teitelbaum, M.D., Clinical Assistant Professor of Medicine at WSU. Program chairmen are Robert C. Douglass, M.D., WSU Clinical Assistant Professor of Medicine, and Joel I. Hamburger, M.D., WSU Clinical Assistant Professor of Medicine.

William S. Reveno, M.D., WSU Clinical Associate Professor of Medicine will discuss "Thyrocalcitonin." J. Joseph Pendergast, M.D., and J. Martin Miller, M.D., of the Henry Ford Hospital, will present a paper "Thyroid Reserve in Euthyroid Patients after Ablative Therapy for Diffuse Toxic Goiter."

Robert E. Mack, M.D., WSU Professor of Medicine, will discuss "Thyroid Function in the Newborn." Doctor Hamburger will speak on "The Contribution of Scanning to the Clinical Diagnosis of Thyroid Cancer."

Doctor Teitelbaum will give a case presentation entitled "Emergence of Peripheral Arterial Insufficiency During Treatment of Hypothyroidism." George Kadian, M.D., WSU Clinical Instructor in Medicine, will give a case presentation on "Thyroid Cancer 17 Years After X-Irradiation." A case presentation "Hydrocoele, A Manifestation of Myxedema" will be given by Doctor Douglass and Donald J. Jaffar, M.D., WSU Clinical Professor of Urology. A case presentation "Thyroid Function Studies in Untreated Pernicious Anemia" will be given by E. Marshall Goldberg, M.D., WSU Clinical Assistant Professor of Medicine.

MSMS TO BE REPRESENTED AT AMA CONGRESS

Recommended by the MSMS Council to attend the AMA Second National Congress on Socio-Economics of Health Care at Chicago, March 22-23, 1968, were: Robert J. Mason, M.D., Birmingham; Bradley M. Harris, M.D., Ypsilanti; and also Richard M. Campau, Herbert Mehler and Hugh W. Brenneman of the MSMS staff.

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ACTIVITIES, PROJECTS

FIRST PROGRESS REPORT ISSUED BY ECHO

Project ECHO (*Evidence* for *Community Health Organization*) has recently issued a first progress report in Michigan.

A project of the Michigan Center for Health Statistics, a division of the Michigan Department of Public Health, ECHO will develop a continuing appraisal of the health of the people of Michigan, and their social and physical environment, It will report these findings to the public and to local health programs.

A detailed explanation of the project will be carried in the February issue of *Michigan Medicine*. Authors are Morris Reizen, M.D., director of the Ingham County Health Department, and Robert Lewis, Ph.D., director of the Center for Health Statistics.

MICHIGAN DENTIST LEADS ADA AS PRESIDENT

F. Darl Ostrander, D.D.S., Ann Arbor, has begun his term as president of the American Dental Association. His wide experience in organized dentistry includes six years as speaker of the House of Delegates of the ADA. He has also been editor of the *Journal of the Michigan State Dental Association*, president of the MSDA, and for 18 years served on the ADA Council on Dental Therapeutics.

SEES PHYSICIANS LEADING CAR SAFETY EFFORTS

Charles E. Black, M.D., Lansing, addressed the fall seminar of the Michigan Adjusters Association in Frankenmuth on the "Autopsy Protocol" as it applies to the insurance adjustors and the insurance industry.

Doctor Black expressed the opinion that the physician is in position to lead in the anticrash-antiair-pollution automobile in the prevention of death and disease. "Man's closest friend in work and in play is the automobile, and is also man's greatest killer rivaling cancer and heart disease in the enormous death toll on our highways," he said.

Attorney Ralph Nader, who also spoke, stressed the need to improve automobile construction and to reduce air pollution by autos.

DETROIT CAREER PROGRAM TO USE "HORIZONS UNLIMITED"

Each year, during the first or second week in May, the Institute for Economic Education and the Detroit Public Schools sponsor a "Careers Unlimited Week" for high school juniors.

Various Detroit businesses and organizations arrange for groups of students to learn first-hand about career possibilities in the field of the student's choice.

Students who have indicated an interest in a health career will be hosted by hospitals around the city. This year, instead of furnishing a great number of pamphlets on particularized health careers, the Greater Detroit Area Hospital Council will provide the students with copies of *Horizons Unlimited*, the AMA booklet on health careers with a MSMS insert on where to get Michigan training in the health fields.

Physician's Cooperation Needed On Retardation Questionnaire

A special project in mental retardation is being undertaken by the Department of Health Development of the University of Michigan. This is a Public Health Service sponsored research to obtain the practicing physicians' opinion about the needs of mentally retarded children in his community.

Much pressure and considerable funds have been made available for a great expansion of facilities for the mentally retarded. Valuable time will be solicited for these programs from local physicians. Since they will be directly involved, it seemed important to those responsible for the special project to find out from physicians what they see as the needs in giving care to the mentally retarded.

The questionnaire is designed to be completed with the aid of an interviewer in approximately thirty minutes or less. The questions are designed to supply the following information; the number of patients with mental retardation seen and the frequency of these visits to the physician's office, present facilities available to the physician, brief generalizations about how each case is handled, and an opportunity to make recommendations for improvement of present programs.

All information will be treated confidentially. The information will be made available to the Michigan State Departments of Health and Mental Health and a scientific report will be prepared for publication in the near future.

This seems to be an extremely worthwhile project and one that is well worth the time of each physician who is interviewed. Your cooperation is urgently requested.

—George H. Lowrey, M.D.
Scientific Editor

HELPS PHYSICIANS FIND FOREIGN ASSIGNMENTS

AMDOC (abbreviation for AMerican DOCtor) is a non-profit corporation whose purpose is to aid people in the health sciences find foreign assignments. The organization is neither religiously oriented nor a government agency. AMDOC's roster of hospitals in foreign areas contains requests for general practitioners, specialists and allied personnel. The locations include South America, Central America, the Far East, Asia and Africa.

AMDOC receives applications from physicians, dentists and allied personnel for foreign assignments. They offer to serve as volunteers for periods from one month to three months or longer without compensation. They finance their own transportation. Their motivation may be a desire for broader experience or for giving of themselves, or both. It can be a challenging, rewarding and exhilarating experience. AMDOC encourages family participation as a means of education in basic international human understanding.

AMDOC assignments are acceptable for educational credit by the American Academy of General Practice.

Further information may be obtained in the office of the Executive Secretary, 27 East Canon Perdido Street, Santa Barbara, California 93101.

PHYSICIAN WINE TASTERS MEET IN DETROIT

To most people, wine appreciation is based on the practical norm of like or dislike.

A group of Detroit doctors, however, are involved in a unique educational program which takes an intellectual as well as a practical approach to the fruit of the grape.

Called the Physician's Wine Appreciation Society, the group at present numbers 25 members.

Organized last March, the society has held three meetings involving lectures, movies, and the existential method of education through actual wine tasting. Champagne was the center of attention in April, the summer meeting focused on California table wines, and the November meeting on Cognac. Wines for the tasting sessions are donated by the industry and its distributors.

Members of the society pay dues of $15 a year and receive subscriptions to several wine magazines, invitations to three or four gourmet dinners throughout the year, and, of course, the wine tasting evenings.

MSMS members may obtain further information from Charles J. Holt, Jr., M.D., Secretary to the Society, at 19515 Mack, Grosse Pte. Woods. Tel: TU 1-7277.

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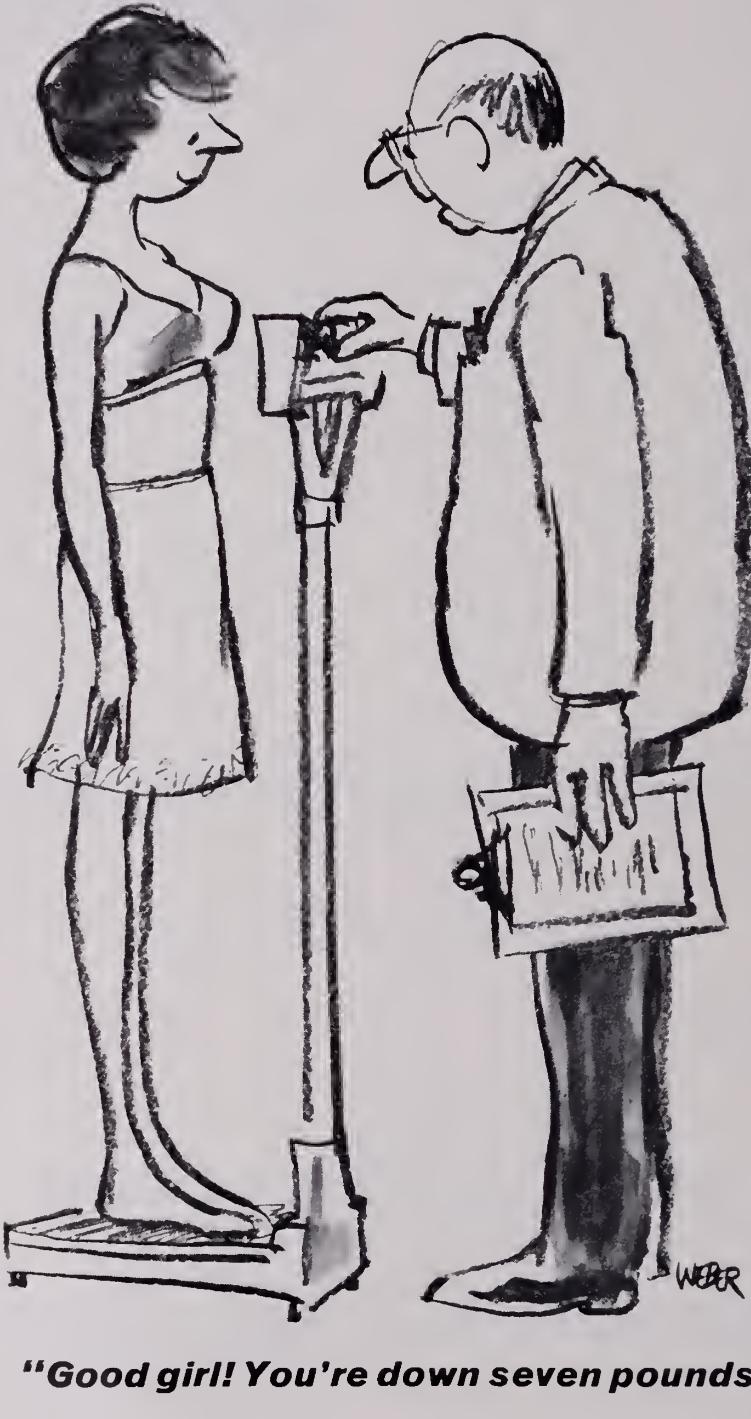

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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NEW SCHOOL NAMED TO HONOR FLINT M.D.

A Flint elementary school, which will open in the spring of 1969, will be named after T. Wendell Williams, M.D., a prominent negro physician from Flint who died in December 1966.

The school, to be built on Utah Avenue near Whaley Park in Flint, will have an enrollment of approximately 850.

Doctor Williams, a pediatrician, was the first negro to serve on the Flint Board of Education. Between the years 1963-1967 he served as both secretary and treasurer of the Board.

On announcing the decision to name the school after Doctor Williams, the Flint Board of Education said "It is especially appropriate that this school be named for a man who possessed an inherent faith in his fellow man's ability to bridge the gulf of racial, social, and economic differences — a man who worked constructively to impart better understanding and a broad range of positive cooperation among all people."

SHARE YOUR JOURNALS

FROM WORLD MEDICAL ASSOCIATION

Michigan doctors are being asked to send their medical journals — after they have read them — to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals.

We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (*particularly specialty journals*), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will.

If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, M.D., Director, % The World Medical Association, Inc., 10 Columbus Circle, New York, New York 10019.

WINS PEDIATRIC AWARD

Cameron Haight, M.D., chief of the thoracic surgery section in the University of Michigan Medical Center, has won the 1967 William E. Ladd Medal of the American Academy of Pediatrics. Given annually, the award honors him for his development of an operation to correct esophageal atresia and tracheo-esophageal fistula.

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CHICAGO MEDICAL SOCIETY

FEBRUARY 25-28, 1968

Palmer House, Chicago

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For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan
Chicago, Illinois 60604

MICHIGAN STATE
MEDICAL SOCIETY

Every day, Michigan newspapers carry articles about medicine. Many of the articles are news releases processed by MSMS or are developed from tips and ideas relayed by the MSMS staff to editors and reporters. In the photo, several MSMS members look at some of the newspaper stories which were carried during the 1967 MSMS Annual Session, which is always a high point in the flow of news. MSMS placed a congratulatory advertisement in the current issue of Michigan Publisher, the official publication of the Michigan Press Association, commemorating the MPA on its Centennial year of service to Michigan readers.

WAYNE STATE INITIATES LEARN-BY-PHONE SYSTEM

By simply dialing a telephone, Wayne State University students can "retrieve" missed lectures, take tests and listen to assigned tapes through a dial access system being developed by the University's new Learning Resources Laboratory of the Systems, Distribution and Utilization Department (SDUD).

Dr. Thomas W. Roberts, Jr., director of SDUD, sees the dial access system as a significant breakthrough in the effort to reach more students in the face of increasing faculty shortages. He hopes this system will free instructional time to permit faculty members to relate more closely with their students.

"Within 10 years," predicts Dr. Roberts, "computers will perform switching operations and store learning materials so that students will actually talk with computers."

By using a cathode ray tube, a light pen, and a typewriter key board, students will ask the computer questions and answer those presented by the computer. The computer will tell if their answers are correct.

Students at home unable to reach the campus due to illness will "retrieve" lectures by telephone.

Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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"FACTS ON QUACKS" AVAILABLE FROM AMA

Speakers at the quackery conferences which MSMS will be sponsoring throughout Michigan in 1968 undoubtedly will rely on "Facts on Quacks," a new AMA publication, for much of their information.

The 32-page, illustrated booklet summarizes information about all kinds of health quackery in the United States. Written for the general public in question-and-answer form, the booklet covers quackery in arthritis and rheumatism, cancer, nutrition, weight reduction, over-the-counter drugs, alcoholic nostrums, health books and pamphlets, epilepsy, mental health and retardation, cosmetics, baldness, rejuvenation, and sex stimulants. The booklet also includes advice on what a person should do if he suspects health quackery activities in his community.

Various governmental and voluntary agencies in the health field such as the National Health Council, the Food and Drug Administration, the National Better Business Bureau, the Post Office Department, the Federal Trade Commission, the American Cancer Society Inc., and The Arthritis Foundation are giving full cooperation to the AMA in the publication of "Facts on Quacks."

To get the booklet write: AMA Order Department. Single copies, 30¢; 50-99, 28¢; 100-499, 25¢; 500-999, 23¢; 1,000-over, 20¢.

U OF M SURGERY PROFESSOR NAMED TO SPECIAL BOARD OF MEDICINE

The National Academy of Science has set up a Special Board of Medicine and one of the 21 people chosen to serve on it is Charles G. Child, III, professor of surgery at the University of Michigan Medical School.

The purpose of the Board, outlined by Academy president Frederick Seitz, is to study means of more effectively applying rapidly expanding biomedical knowledge to critical human needs. Problems to be considered by the Board include such things as the ethical and legal implications of experiments involving humans and the role of medical schools in amelioration of urban and rural slums.

LAFAYETTE CLINIC PATIENTS SEEK WORK CONTRACTS

The industrial Work Program at Lafayette Clinic is seeking contracts and project work for patient workers who are paid for their services. Facilities of the program include a complete power wood shop, a computer laboratory, and a duplicating department. The workshop is also equipped to handle mailing jobs, including sorting, stuffing and packaging.

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Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

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You might also say that all interns aren't alike, either.

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Mrs. Clarence F. Miller presents Hemann K. Pinkus, M.D., with coveted DAR medal, while Hilda Hensel, M.D., also a recipient, looks on.

HUSBAND AND WIFE MDs HONORED BY DAR

Hermann K. Pinkus, M.D., and his wife, Hilda Hensel, M.D., Monroe dermatologists, recently became the first husband and wife to receive the Daughters of the American Revolution Americanism medals.

The Monroe Nancy DeGraff Toll Chapter presented the medals which are awarded by the national organization to adult naturalized citizens who have distinguished themselves as American citizens.

Doctor Pinkus and Doctor Hensel, both born in Germany, came to the United States as refugees in 1934 and 1935 and were naturalized in 1939 and 1940, establishing their practices in Monroe in 1940. They received their medical education in Germany and pursued advanced studies in the United States.

For the past 20 years, Doctor Pinkus has been a professor of dermatology at the Wayne State University Medical School and in recent years has headed the department. He has also participated in research at the Detroit Institute of Cancer Research since 1951.

KALAMAZOO RADIO SHOW CONTINUES POPULARITY

A five-minute, twice-a-week radio show, "Tell Me, Doctor," has been on station WKZO in Kalamazoo for the past 21 consecutive years.

Originally begun by MSMS, the program is now sponsored by First Federal. Each program consists of one question and an answer. Mental health, personal problems, effects of overtime work, epilepsy — these are some of the topics which have received a large amount of listener response, according to Irene Cowles, continuity writer for the station.

"Tell Me, Doctor" is on Tuesday and Thursday at 9:40 a.m.

Committee Seeks Information On Vietnamese Children

During the Korean war, many Michigan physicians adopted or sponsored the education of Korean children. The International Health Committee of MSMS is interested in finding out if any Michigan physicians are doing the same with Vietnamese children. If you are, please drop a note to MSMS, International Health Committee, 1010 Antietam, Detroit 48207.

FAMILY PLANNING DISCUSSED AT U OF M CONFERENCE

If you read newspapers you are more likely to practice family planning, according to Dudley Kirk, Ph.D., a Stanford demographer, citing a United Nations study which found newspaper circulation the most significant of 12 influences on national fertility figures.

Professor Kirk, speaking at the recent U of M sesquicentennial conference on "Fertility and Family Planning: A World View," pointed out that "information, health, and education items were found to be more closely correlated with fertility than economic, industrial, and urban development" in developing countries.

The population growth of 30 nations, including the U.S., is essentially under control. Population increases by 1 per cent or less a year in these nations.

The world population problem, according to Kirk, is related to whether or not the developing nations will follow the lead of Europe and America. Eight countries are in a transitional stage, approaching population control. Twenty-three countries in the developing regions have family planning programs.

"We are at a dynamic, perhaps decisive stage in the demographic transition," Kirk concluded. "It is a reasonable prediction that family planning will succeed and that, before the end of the century, most of the developing countries will be well along the transition to lower fertility and relief from the problems of rapid population growth."

The U-M conference also heard Richard Easterlin, economics professor and researcher at the Population Studies Center at the University of Pennsylvania, discuss the influences which bear upon American parents when it comes to family planning decisions.

Professor Easterlin stressed that income and attitudes were closely related in fertility decisions and called upon economists and sociologists to stop ignoring each other and develop a unified socio-economic framework for fertility studies.

HANDY BIBLIOGRAPHY ON HEALTH CAREERS:

Many MSMS members are explaining the need for more doctors and health-team workers in speeches to school assemblies, luncheon clubs, women's groups, church circles, lodges, unions, et al.

The AMA provides the following bibliography to help provide up-to-date health career information:

Utilization, Recruitment and Training of Health Manpower; Lenor S. Goerke, MD, M.S.P.H., American Journal of Public Health, 55:1511, October 1965.

Some Aims of Health Career Councils; Kevin P. Bunnell, Ed.D., Journal of School Health, 36:416, November 1966.

Teenagers Learn About Health Careers at Statewide Conferences; Cherry Parker, R.N., Hospitals, JAHA, 38:74, October 16, 1964.

Hospitals and Schools Unite in Manpower Training Program; Robert M. Sigmond and Thomas E. Callahan, Hospitals, JAHA, 39:40, July 1, 1965.

Year-round Programs Set the Pace in Health Careers Promotion; Dorothy E. Johnson, Hospitals, JAHA, 40:57, January 16, 1966.

Horizons Unlimited; A Medical Careers Handbook, March, 1967 edition, American Medical Association, Program Services Department.

The Hospital People; (82-page, color Hospital Careers Booklet), 1967 edition, The Blue Cross Association (available through state and local Blue Cross Plans).

Put Yourself in This Picture of Health; 18½" x 22⅞" color Health Careers Poster, American Medical Association, Order Department. (single copies, $1.00; five or more, $0.50 each.)

The Opportunities and Rewards of Medicine Can Be Yours; pamphlet, 1966, American Medical Association, Program Services Department.

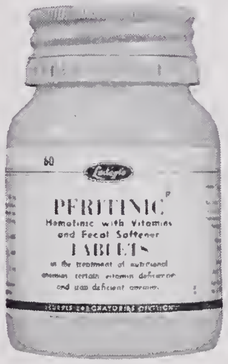
A List of More Than 30 Medical Careers Films Available for Loan; American Medical Association, Films Section.

Long-Playing Record Featuring 20 Health Careers Spots; (Designed for radio programming, but suited for use at health careers exhibits), American Medical Association, Program Services Department.

See John Run!

Washington State Heart Association has dropped the scare technique and is trying the light touch in propaganda against smoking. They talk about the pleasures of not smoking — better tasting food, unstained fingers, and whiter teeth. Non-smokers presumably can run faster to the bank with all the money they save by not smoking.

anticostive* hematinic



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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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MEDICAL PRACTICE TODAY DISCUSSED IN NEW AMA BOOK

To help new physicians and medical students grasp the complex dimensions of medical practice today and how it relates to the total community, the AMA has published a new 99-page handbook called *The Physician's Career.*

The Physician's Career results from suggestions made at recent AMA House of Delegates meetings. It was recommended that information on medical ethics, medical civics, and socio-economic aspects of medical practice would help students bridge the gap between medical school and actual practice.

The book, divided into 15 chapters, focuses upon the vast changes which have occurred since the time when the unaided physician was almost the only health resource in the community.

Group practice, the complex modern hospital, medical staff organization and responsibilities, community health services, governmental health programs, voluntary health insurance and prepayment plans — these are just some of the topics which are covered.

Copies can be obtained at 75¢ from: AMA Order Department, 535 N. Dearborn, Chicago, Ill.

ST. CLAIR COUNTY STUDIES TB SCREENING RESULTS

The results of the demonstration program that tested school personnel for tuberculosis in the Port Huron area this past fall are still being studied by the St. Clair County Health Department.

Robert E. Rowe, M.D., Director, St. Clair County Health Department, reports that, "So far we have found, out of a total of 708 school personnel tested, no active cases. However, 80 people, or 11% of the total, showed positive skin tests. Two people are still under study and are having further tests made."

The Southeastern Michigan Tuberculosis Detection Project moved into Port Huron under the sponsorship of the St. Clair County Health Department, to give T.B. tests to school personnel in the area.

The need for a demonstration program, explains Doctor Rowe, was the 1967 amendment to the Michigan Education Act requiring that school personnel get a yearly T.B. test.

"The new state law," Doctor Rowe recalled, "came about because of a case in Garden City in December 1965 when a teacher in a nursery school infected 18 children."

"While T.B. screening for school personnel is not specifically a health department responsibility, we thought we could help this year to fill the need created by the new law," he said. "We were lucky to get the assistance of the Southeastern T.B. Detection Project."

How could other communities organize to fulfill the requirements of the new law? "In smaller communities the doctors could organize a similar technical team to go from school to school or do the testing in their offices," Doctor Rowe advised. "In the larger areas, the Board of Education could contract with a T.B. testing team similar to the way we did it here."

"We don't plan to carry on the program next year," Doctor Rowe concluded, "because it is really a Board of Education responsibility."

MSU MED STUDENTS LEARN SENSITIVITY TO PATIENTS

"Simulated patients" and closed circuit television are helping beginning medical students at Michigan State University learn the "art" of medicine, along with the science.

The simulated patients are actors and actresses who have been coached to relate specific sets of symptoms and personality characteristics during interviews with medical students.

The primary aim is to enable medical students to become sensitive to the individual patient. This involves learning to relate to the patient, to bring out anxieties that may not be apparent, and to be at ease when discomforting subjects are brought up. Actual diagnosis of each case is only a secondary goal.

Each student conducted four interviews which were viewed live on closed circuit television by the instructor and other students and then played back to the interviewer and class. During the critique sessions, the instructor was able to stop the TV tape whenever he or the students wanted to discuss a particular point, such as possible rephrasing of a question.

One of the originators of the program, Hilliard Jason, M.D., Ed.D., director of the Office of Medical Education Research and Development said, "Simulation enables the student to focus on individual interviewing skills for practice and mastery. And, because the conditions are controlled and uniform, the instructor can make valid and helpful evaluations."

"An interesting point about using simulated patients," Doctor Jason noted, "is that the interviewer soon forgets the simulated patient is an actor or actress and becomes as involved as if the case were a real one." The cases, though different, all had something to do with pregnancy or the reproductive process, in order to make the current lectures and laboratory work of the students more meaningful.

Several Lansing physicians participated in the instruction and reported that they also benefited from the sessions.

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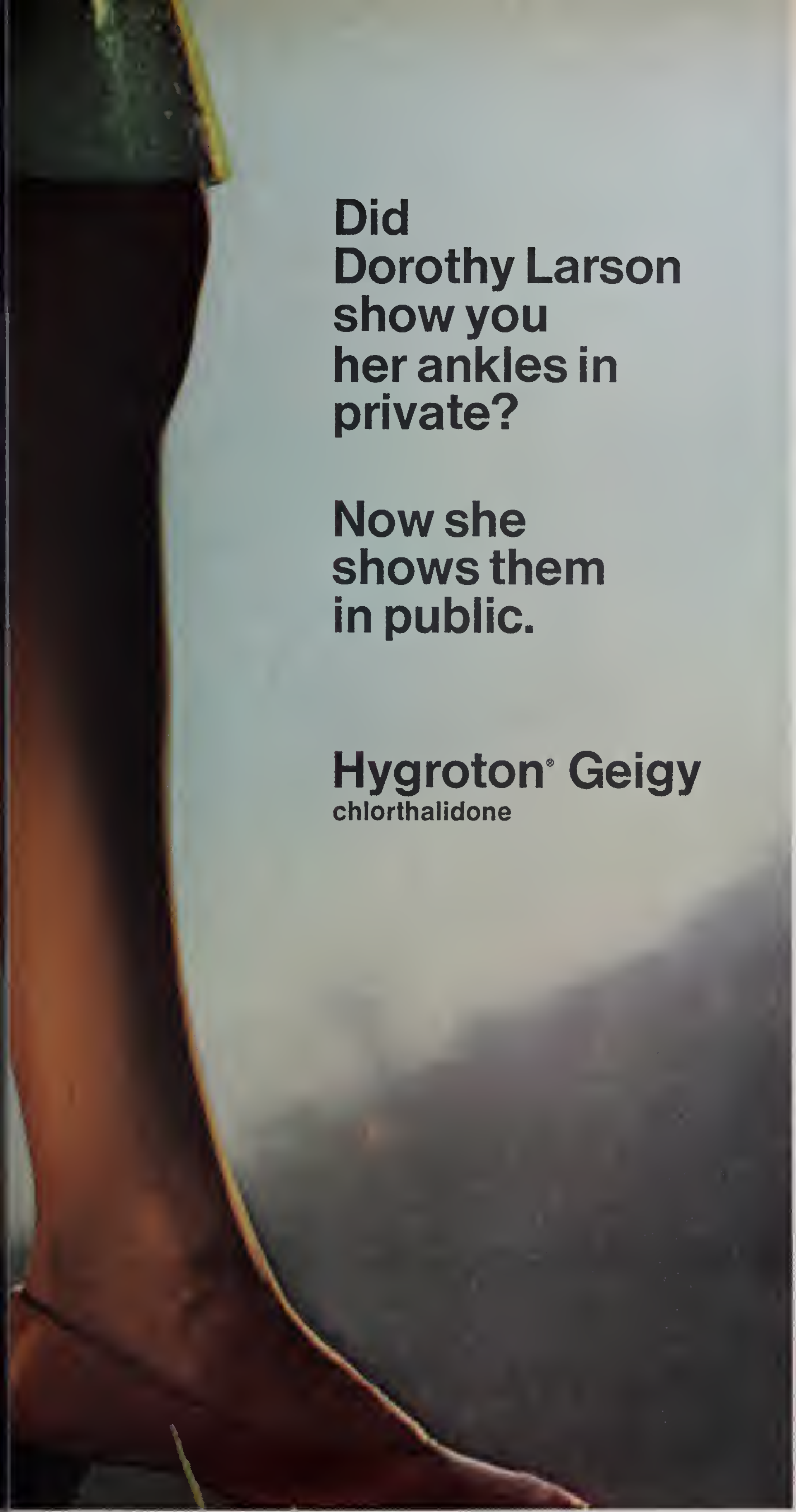
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possi-

foration) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reac-

mia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce [illegible]

may potentiate hypotension. Because of the possibility of progre
sion of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN ris
or liver dysfunction is aggravated
Hepatic coma may be precipitate
Electrolyte imbalance, sodium ar
or potassium depletion may occu
If potassium depletion should oc



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ent does not have marked oli-
a.
special care in cirrhosis or
re ischemic heart disease and
atients receiving corticoste-
s, ACTH, or digitalis. Salt re-
tion is not recommended.
erse Reactions: Nausea, gastric
ation, vomiting, anorexia, con-
ation and cramping, dizziness,

tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia

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For full details, please see the complete prescribing information.

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Recalls Services of Detroit Doctor, Eberts, Beginning of 19th Century

(Editor's Note: — MSMS members, especially those in Detroit, will be interested in the early medical experiences of Herman Melchior Eberts, M.D., who was one of the first physicians in private practice in Detroit. Many of the adventures of Doctor Eberts, who arrived in Detroit in 1791, are described in Doctors Under Four Flags by Fannie Anderson and published in 1951 by The Wayne University Press. The following excerpts are published with permission.

"Herman Melchior Eberts, M.D., was one of the first medical practitioners to come to Detroit without some governmental or military connection. He was born in the city of Augsburg in 1753 of a family which claimed nobility. His medical education was acquired at the University of Vienna and the Allgemeine Krankenhaus, and he was supposed to have had graduate work at the University of Edinburgh.

"In 1774 he was commissioned an assistant surgeon in the *Landwehr,* but early in 1776 he accepted a commission as surgeon to the Hanau Hessian Regiment (Artillery), commanded by Colonel von Gall, which was in the pay of the British Government. The regiment sailed from Portsmouth on April 4, 1776, and arrived off Quebec on June 1. It spent the winter of 1776-77 in Montreal and fought at Ticonderoga. After serving fifteen months in the army, Eberts, at his own request, was granted an honorable discharge and safe-conduct at what is now Castleton, Vermont, on July 13, 1777. The discharge was written in French and described him as *"chirurgien et docteur."* On April 8, 1780, he married Marie Françoise Huc of Montreal. He was one of the first to conform with the Canadian Medical Act of 1788 requiring an examination and license to practice medicine in the Province of Quebec. The commissioners found that "he has been regularly bred to the profession of Surgery and we conceive he may be licensed to practice in Surgery and Pharmacy, or as an Apothecary." At this time he resided in Longueuil, District of Montreal.

"In 1791 he performed an autopsy on a young woman, contrary to the precepts of the Roman Catholic Church, and public opinion forced him to leave Montreal hurriedly.

"It was at this point in his career that he came to Detroit, but his family did not follow until 1795 or 1796. According to family records, he kept a drug store, sold wines and spirits, and dabbled in the fur trade, as well as following his profession. His home was near the corner of what is now Larned and Shelby streets.

"Eberts became coroner in 1796, one of the first appointments made by Winthrop Sargent for the newly organized County of Wayne. At the same time, George McDougall was appointed sheriff. When later in the year McDougall planned to leave on his usual winter trading expedition, he made an agreement with Eberts whereby the latter also took over the duties of the sheriff and paid McDougall a share of the fees accruing. This was done with the consent of the Judges, and McDougall went off to winter with the Indians. Eberts' commission as sheriff was revoked by the Governor of the Territory in 1798, in part probably as a result of Eberts' irascibility.

"In 1804 Marie Huc Eberts filed suit for divorce before the Circuit Court at Detroit, retaining Solomon Sibley as her attorney. It was asserted that her husband had "an ungovernable, cruel and unrelenting temper and disposition." Furthermore, he had not provided the necessities and convenience of life for her and their seven children, and on several occasions he had beaten her without cause. She asked for a divorce and alimony and was given a legal separation, whereupon she returned to Montreal. It was necessary to issue a warrant before Dr. Eberts appeared at the judge's chambers as ordered to sign the final papers on November 2, 1804.

"After the fire of 1805, in which his home was destroyed, he moved to the Canadian side of the river. During the War of 1812 he served as staff surgeon to General Henry Proctor's forces, and his four eldest sons also fought on the British side. For a second time he suffered the loss of his home by fire when the American troops invaded Canada in 1813. Among other valuables, a collection of botanical specimens, gathered in Michigan, was destroyed. After the war he resumed practice· cultivating a number of medicinal herbs in his own garden.

"He died on September 24, 1819, at the age of sixty-six and was buried by the Reverend Richard

Continued on Page 114

Pollock in the churchyard of St. John's Anglican Church at Sandwich.

Doctor Eberts was a gifted linguist, speaking German, French, English, and Latin, It is known that he kept meticulous records of his cases. Until a few years ago one of his case books was still in existence, but this too has disappeared. Fortunately, a description of it was published in a Detroit newspaper some forty years ago. It was a closely written manuscript containing about 350 pages, twelve inches long by eight inches wide, bound in parchment, and originally fastened with two clasps. Its first page was ornately written, possibly by a professional scrivener,

Livre de Compte
Pour
Medicament et Operations
De
Herman Melchior Eberts
Docteur au Medicine
Detroit
Premier Janvier
1796
Dat Galenus Opes.

"Patients came to Eberts from both sides of the river for some distance and among them were John Askin, Dr. William Brown, and Dr. William McDowell Scott. On occasion, Eberts probably contracted to provide medical care for a specified sum for a period of time. On May 15, 1811, Thomas Louis of Sandwich received a price of L4 for one year's medical care, and his family was treated at intervals through September 17, 1811. Apparently, cases which demanded more than the routine treatment of ordinary sickness were charged extra, and although the entry, "Received payment in full, L18," is undated, the confinement of Madame Louis on March 11, 1812, evidently required an additional L4.

"In some instances, however, patients refused to pay, and Eberts had to resort to legal pressure in order to collect. In December, 1796, the doctor brought suit in the Court of Common Pleas against a Joseph Thiebaut, Jr. for the non-payment of a bill for professional services. The court referred the matter to Drs. William Harffy and Charles Brown, surgeon to the American Corps of Artillerists and the Engineers at Detroit. Both physicians agreed that the bill should be reduced, and this decision was accepted by the court.

"Excerpts from Eberts' case book make it possible to piece together from several individual records the physician's methods of treatment. Bleeding was done frequently in the arm or foot, and patient medicines, such as Hamilton's Lozenges and Ching's Lozenges, as well as epsom salt and other drugs were prescribed.

"He also practiced obstetrics, which was rather unusual since most of the women in the Detroit area were predominantly of French ancestry and conservative in their ideas. Even in Philadelphia, the foremost city of the nation in culture and scientific advancement, many women still preferred to be attended by midwives. The entries in his case book on the confinement and post-natal care of Madame Thebedeau indicate the procedures followed by Eberts in this field of medicine.

July 10	Medicines	16*s*
	3 visits	8*s*
July 11	Bled arm, attendance	16*s*
July 12	Jalep, etc.	16*s*
July 14	Medicines repeated	16*s*
July 16	Epsom salts	6*s*
	A daughter born to Madame Thebedeau at nine o'clock in the morning; the child presented its right hand and right ear; the birth was miraculous and never seen before. After a half hour of labor I was able to bring the confinement to a happy conclusion	20*s*
July 18	Medicines	16*s*
July 26	Medicines repeated	16*s*
August 22	Salts	4*s*
August 26	Tincture of gentian	16*s*
September 4	Bols [bolus] purgative	4*s*
September 8	Jalap	2*s*
[No date]	Received payment in full	L26, 16*s*

"With the final disposition of the western boundaries and the establishment of a stable government more civilian doctors followed in Eberts' wake, but these men came from the states along the Atlantic seaboard, which had formerly been British colonies and were now incorporated in the United States. The physicians of this early period in American life have been frequently criti-

Continued on Page 118

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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.[1-5]

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New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.[6] (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

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Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.[7-9]

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.

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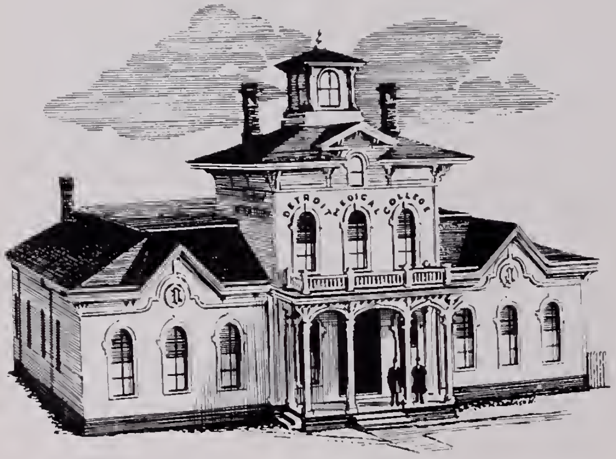
cized for their poor training and education and their lack of scientific interest. This indictment may be true, but a definite pattern, suited to a new country and a society untrammeled by Old World guild restrictions, was slowly emerging. Dr. John Morgan, one of the founders of the Pennsylvania Medical School of the College of Philadelphia, had advocated the separation of the three branches of medical science — medicine, surgery, and pharmacy — but this was not suited to the demands of frontier life.

"In the backwoods a physician was liable to be called for an emergency from dressing arrow wounds to treating malaria, and, as there were no corner drugstores, he usually carried his medicines with him."

MORE PHOTOS FROM WSU SCRAPBOOKS



AT LEFT — Wayne State University, in observing its Centennial, traces its history to the Detroit Medical College which was started in 1868 by a group of five doctors. In 1879 another college, the Michigan College of Medicine, opened in Detroit and the two merged to become the Detroit College of Medicine. In 1913 the name was changed to Detroit College of Medicine and Surgery and in 1919 it became an official part of the Detroit Board of Education in the Colleges of the City of Detroit. In 1933 the name was changed to Wayne University, and in 1956, Wayne became a State institution.

AT RIGHT — The WSU $4-million Medical Research Building, completed in 1964, was the first new medical structure to be erected in the Detroit Medical Center.

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Synthetic Thyroid Replacement Therapy

Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

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In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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Farmers Shifting from Livestock To More Cash Grain Farming

Michigan physicians as consumers and many doctors as part time farmers will be interested in the current report from the Seventh Federal Reserve Bank District that "one of the more significant of many recent changes in Midwest farms has been the strong rise in grain production.

In the current issue of *Business Conditions,* the monthly publication of the Federal Reserve Bank of Chicago, the District officials report a "significant shift from production of livestock and livestock products to cash grain farming." The publication, in part, also declared:

"The proportion of cash receipts from crops marketed in the Seventh Federal Reserve Districts states increased from slightly less than 29 percent in 1959 to about 35 percent in 1964, based on the Census of Agriculture. Although there were fewer farms in 1964 than in 1959, the number of farms on which grain was a major source of income increased sharply both in number and as a proportion of the total of all farm types.

"THIS SHIFT IN TYPE of farm was especially evident in Illinois, Indiana and Iowa—the Corn Belt states of the District—but it also occurred in Michigan and Wisconsin. The proportion of cash grain farms (farms deriving 50 percent or more of their cash receipts from the sale of such grains as corn, small grains and soybeans) increased in Illinois from 38 percent of all farms in 1959 to 48 percent in 1964, from 20 percent to 28 percent in Indiana and from 18 percent to 24 percent in Iowa."

The federal agency reported that dairy farms dropped about 20 percent in Michigan, but because of the equally sharp decline in other types of farms there, the proportion of dairy farms remained nearly the same. In Wisconsin, the nation's leading dairy state, dairy farms declined about 14 percent in number and from about 66 percent of all farms in 1959 to 62 percent in 1964.

Almost all the decline, however, was confined to farms with small herds—the number of cows per acre actually increasing slightly in Michigan and Wisconsin.

FRUIT AND VEGETABLE farms, although accounting for only a small percentage of all farms, are important in some specialized areas, especially along Lake Michigan. These farms increased somewhat relative to other types in Michigan and Wisconsin but declined or showed little change in the Corn Belt states. Poultry farms, also of minor importance compared with all farms, declined in number in all District states, though they gained slightly relative to other farms in Illinois and Indiana.

The number of meat animal farms also dropped sharply during 1959-64—down one-fourth or more in each Corn Belt state. Somewhat smaller declines in Michigan and Wisconsin reflected the more limited farming alternatives in those states.

The Reserve Bank officials reported that "steer numbers increased in most counties of Michigan and Wisconsin, partly reflecting the shift from dairy to beef production on many small farms."

The *Business Conditions* publication explained that "a variety of forces contributed to the shift from the production of livestock to cash grain

Continued on Page 124

treat one . . . six people benefit

The brunt of senility falls on the family as much as the patient. But usually within one or two days, 'Thorazine' can control senile anxiety and fear . . . dispel the confusion shown by nighttime wandering and chattering . . . restore appetite and interest in personal grooming. Treat the senile patient with 'Thorazine'—the whole family can benefit.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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WHAT DOES GALVANIC SKIN RESISTANCE DEMONSTRATE ABOUT THE EFFECT OF VALIUM (diazepam)?

Galvanic skin resistance...one measure of the Valium (diazepam) effect in reducing the somatic response to acute stress[1,2]

The subjective value of Valium (diazepam) has been proved by many clinical and empirical evaluations. Now, also objective criteria such as used in other areas of scientific research have demonstrated the effectiveness of Valium (diazepam) in reducing certain somatic responses to acute stress.

Devised as a research tool in psychosomatic medicine, this interesting method records respiratory excursions, galvanic skin resistance, cardiac activity and finger pulse volume as physical responses to stress. These autonomic nervous system responses to a standardized stressor—a film dealing with life-threatening incidents—are continuously monitored on the polygraph.

This gives a graphic representation of changes which the body may undergo in reacting to stress. The application of modern statistical analysis to these graphs provides a yardstick by which the calming effect of Valium (diazepam) can be measured quantitatively.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with a history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See *Precautions.*)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

References: **1.** Selesnick, S. T., and Clemens, T. L.: From research film "Motion Picture Films in Psychosomatic Research," available from Roche Laboratories. **2.** Clemens, T. L., and Selesnick, S. T.: *Dis. Nerv. System, 28*:98, 1967.

ROCHE

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(diazepam) Roche®

useful for somatic symptoms of psychic tension

farming. Greater possibilities for mechanization of grain farms than other farms have undoubtedly influenced the trend. Such field operations as planting, cultivation and harvesting have been increasingly mechanized, allowing crop farmers to do a given amount of work in less time. This, in turn, has often allowed them either to handle more acreage, intensify production or seek part-time employment off the farm—an opportunity not usually open to livestock producers.

"Also, the development and adoption of other technological innovations have made the highly productive land in the Midwest more suited for intensive cropping."

CROP PRODUCTION in Michigan, Wisconsin, Illinois, Ohio and Iowa, according to the Bank publication rose "about 14 percent during 1959-64. Corn production showed an even more dramatic rise—nearly 18 percent."

"Returns on the capital of cash grain producers in the Midwest also increased steadily throughout the period.

"Reflecting the general improvement in the incomes of grain producers, returns averaged more than for other major types of farms. This undoubtedly encouraged farmers to shift away from lower income enterprises wherever possible."

The publication, in looking toward the future, declared, "It is hard to say if Michigan and Midwest farmers will continue to reorganize their operations in the direction they did in the early 1960s. Returns to livestock feeders and dairymen have improved markedly in the last two years. If it continues, this improvement would, of course, tend to moderate the extent of a further shift toward more extensive cash grain farming. The improvement in returns on livestock may have been only temporary, however, reflecting the very high prices of livestock in 1965 and 1966."

The photos with this article are from the George C. Coats and Sons farm in Barry County and were furnished by the MSU School of Agriculture.

Associations Represent Every Interest Imaginable

Physicians are now paying their 1968 dues to the Michigan State Medical Society and it would be interesting to make a list of all the other associations that one supports through dues and personal participation.

There is no accurate estimate of how many local, state, national, and international associations there are, but the Chamber of Commerce of the United States acknowledged the vital importance of professional and trade associations in 1927 by creating the Association Service Department.

"LET'S GET TOGETHER!" long has been the byword of millions of Americans of all ages, from Boy Scouts to old duffers, who organize themselves into a wide variety of groups, ranging from the Pie Bakers Association . . . to the National Pickle Packers . . . to Girl Watchers Anonymous.

Let's get together! Federations, Organizations, Associations—and ultimately, the biggest American get-together of all—the Nation—all show that we are a people with a firmly rooted belief that things get done, and done better, when they're done in unison.

From the Association of American Poets to the Zoologists Society, the roster, from A to Z, swells to include thousands of associations that represent every interest imaginable.

There's the American Society of Mammalogists, a professional society of scientists, educators and conservationists. The American Mission for Opening Closed Churches is dedicated to re-opening same and helping them to become self-supporting.

If you think that an organization calling itself "The International Concatenated Order of Hoo Hoo" sounds like a convening of practitioners of magic, you might be surprised to learn that it's a fraternal order of men in the lumber industry—with a membership some 14,000 strong!

GIRL WATCHERS ANONYMOUS
?
E. P. MILLER

The popular adage, "You get out of it what you put into it," could very well apply to membership in professional or trade associations. The man who puts some of his time and money into the group of his choice not only helps support the organization and its work, but enriches himself as well.

There is even an American Society of Association Executives, founded in 1920, to keep associations, themselves, on their toes!

The national Chamber of Commerce and the American Society of Association Executives each year sponsor in-service institutes for association executives. (MSMS Staffer Herbert A. Auer is a member of the Board of Regents which plans these institutes at Michigan State University, Syracuse and other colleges.)

PUBLIC RELATIONS

NEWSPAPER, MAGAZINE ARTICLES TELL ABOUT MSMS, AND DOCTORS

BY HERBERT A. AUER
MANAGING EDITOR

THE VIEWS OF Alfred B. Swanson, M.D., Grand Rapids orthopedic surgeon, on medical aid to Viet Nam were featured in a recent full-page article in the *Grand Rapids Press.*

Doctor Swanson urged escalation of "the second war, the war to win the friendsip of the people" through total commitment of medical aid. He was one of the twelve physicians who testified recently before the Refugee Subcommittee of the Senate Judiciary Committee that more money was mandatory. The USAID budget for medical assistance for Vietnam was, nevertheless, slashed by 20%. "The entire idea of vastly accelerating spending for the military aspects of the war, and then cutting back on the expenditures necessary to win over the people, is preposterous," he said.

Doctor Swanson, who has worked in Vietnam three times since 1962 and is now planning his fourth trip, described difficulties in getting even basic supplies and especially polio vaccine through official channels.

His conclusions and proposals were reported thoroughly by *Grand Rapids Press* writer William Schiffel.

* * *

THE HEADLINE SAID "Intensive Care Unit Paying Off" in the *Bay City Times* about the Mercy Hospital Intensive Care Unit which opened there in March 1967. John C. Mayne, M.D., Mercy chief of staff, declared, "The unit filled out a definite need in the community. I think on the whole the medical staff has been very gratified with the results." Doctor Martin Jaffe, head of the hospital's department of medicine, emphasized the usefulness of the unit for heart patients. Other kinds of crises handled were described. Comments by ICU personnel and former patients gave a good picture of the efficient care and cheerful atmosphere of the unit.

The by-line article was by Irene Beyst, *Bay City Times* reporter who participated in the 1967 MSMS medical Writers Conference.

* * *

FOUR COVERS FROM recent issues of *Michigan Medicine* were reproduced by the *PR Doctor* to illustrate the value of cover layouts emphasizing the subjects of leading stories. The covers shown featured sports medicine, a VD eradication campaign, treatment of alcoholism and the MSMS program on "Family Life Education."

The article praised the covers as varied and appealing. "Ever notice how many other journal covers remain static from year to year?" it asked. "Michigan's answer has hypoed eye appeal and reader interest."

* * *

THE RECENT ISSUE of *Auxilium,* the publication of the Woman's Auxiliary of the Michigan State Medical Society, carried a "farewell" article by Marge Karker. Mrs. Karker recently retired to Florida with her husband after serving as women's coordinator on the MSMS staff. In part, Marge wrote to the Auxiliary members,

> "You are an organization for just one reason—to assist your doctor-husbands.
>
> "It seems that there are two programs that should not be neglected:
>
> 1. "The recruitment of people into the health-related fields, by 1970 it is thought that more people will be employed in the health-related fields than in any other. Doctors need helpers—you can help them find them."
> 2. In the field of legislature. Doctors are too few in number to influence greatly in the legislative field. They must have the help of others. Doctor's wives can influence others to write their congressmen and legislators. The Auxiliary is trying hard to get information to doctors' wives relative to legislation."

Mrs. Karker closed her note by telling women to "don't discount or discard the idea that you have influence."

* * *

THE CURRENT ISSUE of the newsletter of the State Medical Journal Advertising Bureau, Chicago, tells all the other journals about a *Michigan Medicine* practice. The newsletter says *Michigan Medicine* has a good idea in running a regular boxed item which says, "The Advertising in *Michigan Medicine* keeps you informed and helps pay for publishing costs. When the local representative calls, tell him you saw his company's ad in your journal." The newsletter says, "there is no doubt about the power of a doctor's favorable comment." SMJAB and *Michigan Medicine* hope too that Michigan physicians "will write to companies whose ad strikes them as particularly good."

* * *

"The legislators who spoke at the recent MDPAC workshop are very devoted, concerned citizens, willing to look into each problem with open eyes before voting on it," declared the editor of a recent issue of the *LCMS News.* That's the attractive monthly bulletin of the Lenawee County Medical Society.

The report of the MDPAC Workshop stressed the importance of communications between the doctor and his legislator. The *LCMS News* observed that "legislators repeatedly stressed that they need the consultation and advice of physicians and others in making up their minds on the vital health issues." The writer reported that the workshop had given him "an appreciation for the life of a legislator, noting the fact that they (the speakers) are all of high caliber. . ."

* * *

Every week newspaper editorials pay tribute to individual doctors and their medical societies for meritorious service. Recently the *Battle Creek Enquirer and News* praised Richard J. Campbell, M.D. We quote, in part:

"People who work in many areas of community service must feel some dismay upon learning that Dr. Richard J. Campbell is about to retire and leave Battle Creek.

"During his years here, Dr. Campbell has given freely of his good counsel and leadership in many and diverse fields, both within and outside of his professional field of medicine.

"To mention only a few, he has been a moving force in the Family and Children's Service in alleviating human problems, in the social services planning of the Calhoun County Community Council, in the health care planning of the Battle Creek Area Hospital Funds, Inc., and its predecessor study committee, in stimulating youth through the Health Career Days he initiated, in youth service through the Boy Scouts of America.

"In more ways than we can count, this gentle and kindly man has contributed greatly to our community. Now that he is about to leave, we can only wish him well, knowing that in the years ahead he will continue to enrich the lives of those around him, wherever he lives. Such a man can't really retire."

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Suggestions on Selecting Medical Library Journals

(Editor's Note: The following article by Louis Krause, M.D., Chairman of the Maryland State Medical Society Library and History Committee, is reprinted from the Maryland State Medical Journal.*)*

With the information explosion librarians are often puzzled regarding selection of journals for their individual libraries. A good criteria for selection is the list of journals indexed in *Index Medicus,* published since 1879 by the National Library of Medicine.

How to maintain quality as well as currency in their selection of journals has been a major problem for the National Library. In response to many suggestions, the Library decided in 1964 to base their decisions on the opinions of special subject specialists acting as a panel.

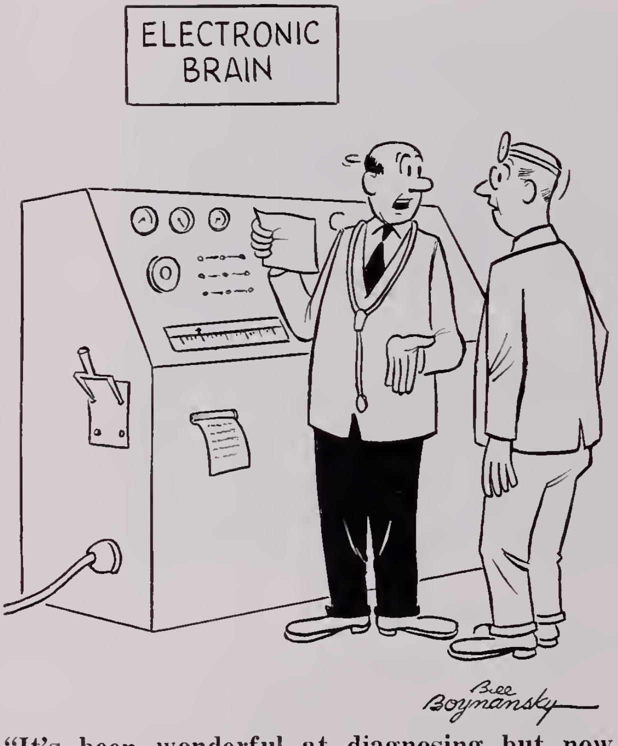
As with other organizations, the limitations of personnel and funds have controlled the number of journals which can be indexed. Initially, during the formation of the panel, the 1000 journals selected from the *List of Journals indexed in Index Medicus,* through a previous 'user' survey as the highest quality journals, were indexed in depth. The other titles were given limited indexing; that is, not over four subject headings were to be assigned to entries.

Following the recommendations of this panel, the chief of Bibliographic Services of the National Library prepared these criteria:

1. Sponsorship of the journal by a professional organization of recognized status in a given discipline or subject area.
2. Sponsorship by a national academy or national institute.
3. Existence of an active editorial board consisting of knowledgeable and critical referees with high professional standing.
4. Regular contributions to a journal by leaders in the subjects to which the journal addresses itself.
5. Strict adherence to an established format in presentation of methodology, tables, graphs, references and other data.
6. Publication policy that prohibits promotional, parochial, or secular approaches in the journal.

This information was excerpted from an article titled *Selection of Journals for Index Medicus* by Leonard Karel, PhD., National Library of Medicine in the *Bulletin of the Medical Library Association,* v.55, number 3, July 1967, p. 259-278. It is a comprehensive review of the subject and suggested reading for persons interested in one of the most specialized indexing projects in the country.

If librarians and physicians wonder why some of their pet publications do not appear on the *LJI* (List of Journals Indexed in *Index Medicus*) this article will shed some light on the methods of selection used.



"It's been wonderful at diagnosing but now it's coming up with diseases we haven't discovered yet!"

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Latest *AMA records reveal the following figures:

300,163 — Total
287,163 — Total in active practice
187,100 — In solo, partnership, group and other
55,126 — In other practice
31,870 (Non-Federal)
21,950 — (Federal)
1,306 — Address Unknown
44,937 — Training Programs
40,709 — Non Federal
4,228 — Federal

GP-SPECIALTIES

70,223 — In general practice
65,591 — Medical Specialties
79,245 — Surgical Specialties
22,128 — Psychiatry and Neurology
48,670 — Other Specialties

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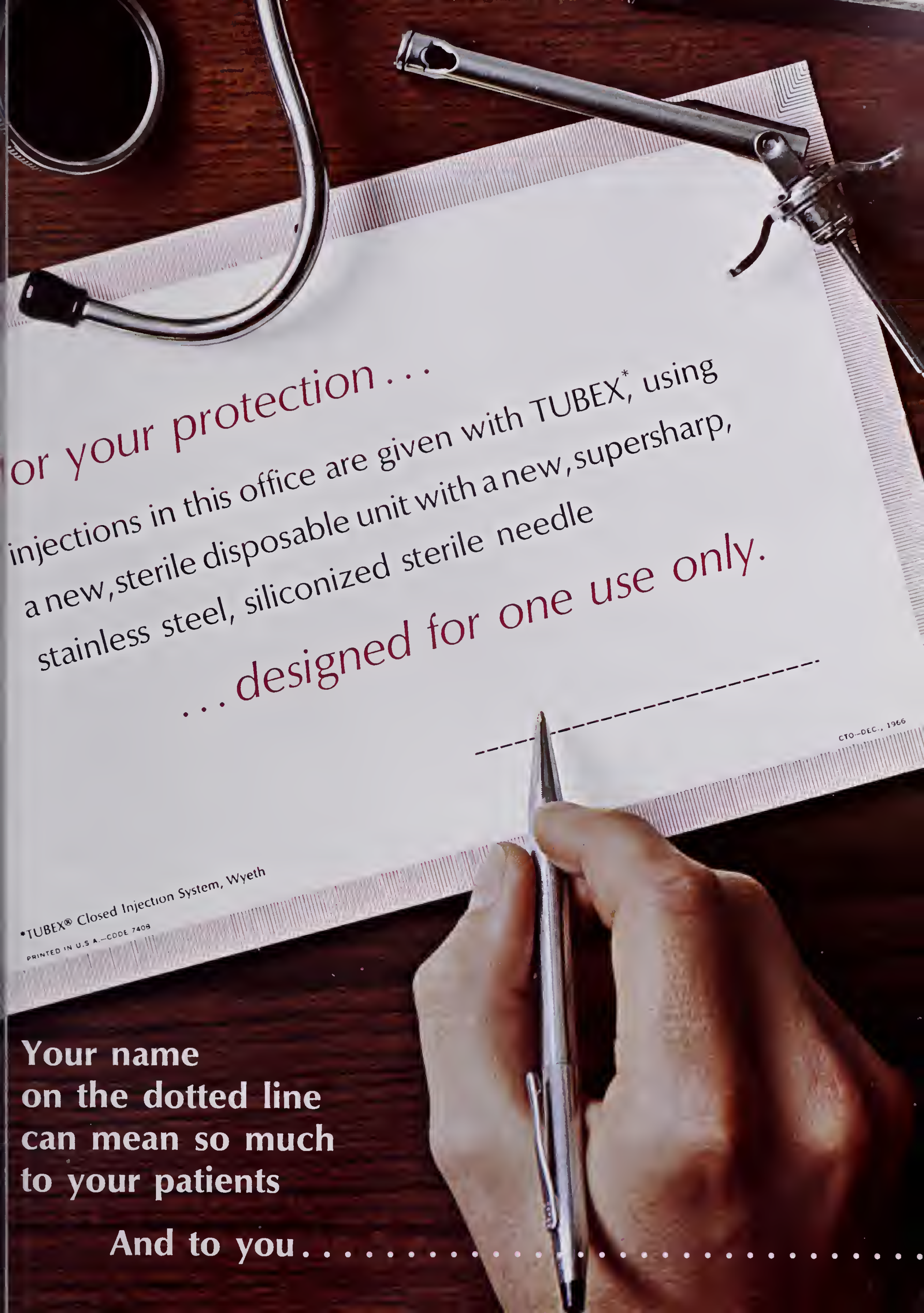
*AMA, December 31, 1966



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GALENS HELP SICK CHILDREN

Thirty members of the Galens Society at the University of Michigan, took to the streets on December 1 and 2 to collect money to continue the children's workshop on the 13th floor of the University Hospital and to finance one in the C. S. Mott Children's Hospital now under construction.

"During the two days we collected $14,400," said Lee Britton, Galen's president. "We hope through the mail solicitation to get another $5,000 to $6,000."

"The reason we take up the collection at this time of year is because Christmas is the worst time for a child to be hospitalized," Mr. Britton continued. "The people of Ann Arbor are generous and proud of the project because they know every bit of the money they give goes directly to the cause to which they give it."

The donations help provide a workshop supervisor's salary, supplies, books, phonograph records, and special events such as carnivals and the annual Christmas party for each hospitalized child. Also three teachers are employed throughout the year to insure that the hospitalized children do not lose any school time.

Since its founding over half a century ago, the Galens honorary society has developed the Medical School's honor system, founded an annual lecture series, developed the system of upperclassmen counseling freshmen, and established loan funds for students. The Galens also sponsor special awards for outstanding students and teachers.

Parke-Davis Official Hits Drug Legislation

A Parke, Davis & Company executive has criticized proposed legislation that would force doctors to prescribe drugs by generic means for patients on Social Security.

"Our senior citizens deserve the right to obtain drugs of the highest quality, potency, and effectiveness," Joseph F. Sadusk, Jr., M.D., told members of the Rho Chi pharmaceutical honor society of Wayne State University's College of Pharmacy.

"It is my sincere belief that physicians should be permitted to prescribe for patients those products which from personal experience have proven to be safe and effective for their needs. The conscientious doctor simply cannot jeopardize the health of his patients by being indirectly forced or induced to prescribe products which may be inferior simply to save some relatively minor expense."

Doctor Sadusk, vice president for medical affairs at Parke-Davis, described as "disturbing" the proposed changes which would take away the doctor's prerogative of either himself designating the source of a drug for his patient or leaving this detail to the pharmacist.

AMERICAN LEGION SUPPORTS FAMILY LIFE EDUCATION

The American Legion and Auxiliary have addressed themselves to one of the goals of the MSMS Committee on Family Life Education, namely that courses stressing preparation for marriage and family life be taught in public schools.

At the Legion's national convention a resolution was adopted which in part, said: "The American Legion urges Posts to contact their local school authorities to ascertain if family life education courses to include such subjects as preparation for marriage and parenthood, as well as nutrition and health, are offered in the school curriculum." The resolution also stated "that in those communities where such family life education curriculum is not provided in the schools, the The American Legion seek the cooperation of the Parent Teachers Association, local medical societies, local public health departments, the clergy and mental health groups, to the end that such courses are instituted in the school system."

VISITOR IMPRESSED BY MSMS CEREMONY

The MSMS awards presentation at the Annual Dinner Dance impressed a visiting dignitary who has proposed that his state medical society "copy" the idea.

George F. Lull, M.D., executive administrator of the Illinois State Medical Society, was the guest who was impressed with the award ceremony. After the Annual Session, Doctor Lull wrote to MSMS Council Chairman Robert J. Mason, M.D., and said in part:

> "This is a brief note to tell you how much Mrs. Lull and I enjoyed our visit to the annual meeting of the Michigan State Medical Society.
>
> I think one of the high spots was the presentation of certificates to the presidents of national organizations and I am going to report this to the ISMS Board of Trustees to see if we can possibly copy the procedure."

The MSMS president at the Grand Rapids dinner presented nine awards to Michigan doctors who are serving as presidents of national medical organizations.

The award is given annually to MSMS members to recognize their leadership in national groups.

MANY SOCIO-ECON ASPECTS RAISED IN URBAN HEALTH REVIEW

BY EDWARD F. CRIPPEN, M.D., M.P.H.
DEPUTY COMMISSIONER
DETROIT DEPT. OF HEALTH

The ferment in the cities and recently the explosions are acts of people, and will not only be solved by construction but will answer the *needs* of the individuals, not his wants. Most of the money poured into cities is aimed at trying to salvage the central city, the downtown, by building malls, auditoriums, parks, parking ramps, the so-called civic centers, inhumane communities within the community, whose purpose is primarily to attract tourists to boost the economy. These are nice places for conventions and to work if you can afford the transportation or parking costs, but cold, lonely noisy places to live with the roar of trucks, screeching of sirens, the flashing and blinking lights.

To answer the *needs* of the *people* we must start by thinking about homes not houses, neighborhoods not super highways or great shopping centers, communities and not metropolitan areas.

TODAY'S MAN IS struggling hard to be an individual, evidenced by the hippies, the reactionaries, the civil disturbances, and the desire to belong to a minority group and preferably two, denoted by statements: "It is bad enough to be poor —to be poor and black is intolerable."

In light of the above, the urban health programs must be aimed at the individual and the family. Thus centers must be identified with and *in* the neighborhoods. They need not be large, may not be economical but should provide round-the-clock emergency service and accessible public health services where there are local practitioners plus medical care where there is none in that neighborhood.

THESE EMERGENCY SERVICES should be under the direction of a physician. In some cities general practitioners are now closing their offices and taking night duty at the hospitals, as total source of income; so could physicians be hired at the health clinics to direct and repair lacerations, puncture wounds, treat toothache, give tetanus and rabies shots, tend a midnight fever, detoxify alcoholics, evaluate mental crisis and perhaps give some therapy if not drugs, pump out swallowed poison, diagnose and treat venereal disease, perform multiple screening exams including pap exams, examine and make proper referrals of surgery or medical patients. He should be supported by a clinical and public health nursing staff that would relate to the family in the home and in the *neighborhood* school and nursing homes.

This neighborhood should have its school, its home of health, its park or recreational area. Thus each person in the neighborhood can relate to where he lives as his community. There will be less desire to destroy it. The advantages of a small town are thus built-in.

THE URBAN HEALTH departments must and need to take a part in housing inspection. Noise levels as well as inadequate lighting must be controlled. Schools must have and abide by the same health recommendations as the hospital; that is, adequate lighting, space, restrooms and health protection. Urban hospitals need also to be brought up to basic standards for health.

It is not unrealistic to have such a center for every neighborhood of 5,000 people. This would mean 500 for all of Detroit; as compared to less than a handful at present.

Real effort must be made to promote cleanup and fly and rat control in each area to be carried out by the neighborhood. Cities themselves must control the air pollution where there are the major sources, and the water pollution. Urban areas are where cities find pollution most difficult to abate.

Sewer, air, solid waste, water control must be under the metropolitan authority because they are better controlled and cheaper. With the abatement of water pollution, more rivers and lakes will provide more safe recreational areas.

The cost of follow-up of immunization, tuberculosis and venereal disease is much more expensive because of the rapid relocation of some families for various reasons—mostly economic, lack of neighbor association, no orientation to family or culture, and a jungle of dilapidated houses.

SCHOOL FUNDS ARE more limited because of lowering tax base and thus few school systems support the school health program financially. In city-county areas of public health, population increase allotments are frequently made on the last census which in some cases means no money is appropriated for thousands of recently arrived disease-ridden people in the city.

Transportation is a real problem in giving and providing medical care. Buses are expensive and may not go in the right direction. Cars are not cheap. Nursing homes also should be in the neighborhood, the "Village in the City."

Lastly, but by no means least, public health laws need to control occupancy and even population of areas.

Many of the health problems in the city could be solved by (like Puerto Rico did) shipping one-fourth of us out of the city to another smaller one, but that would only create more problems for the Federal government elsewhere. Thus the storm over the cities goes on. Can we build a dam that will protect us from the threatened flood? We have to!

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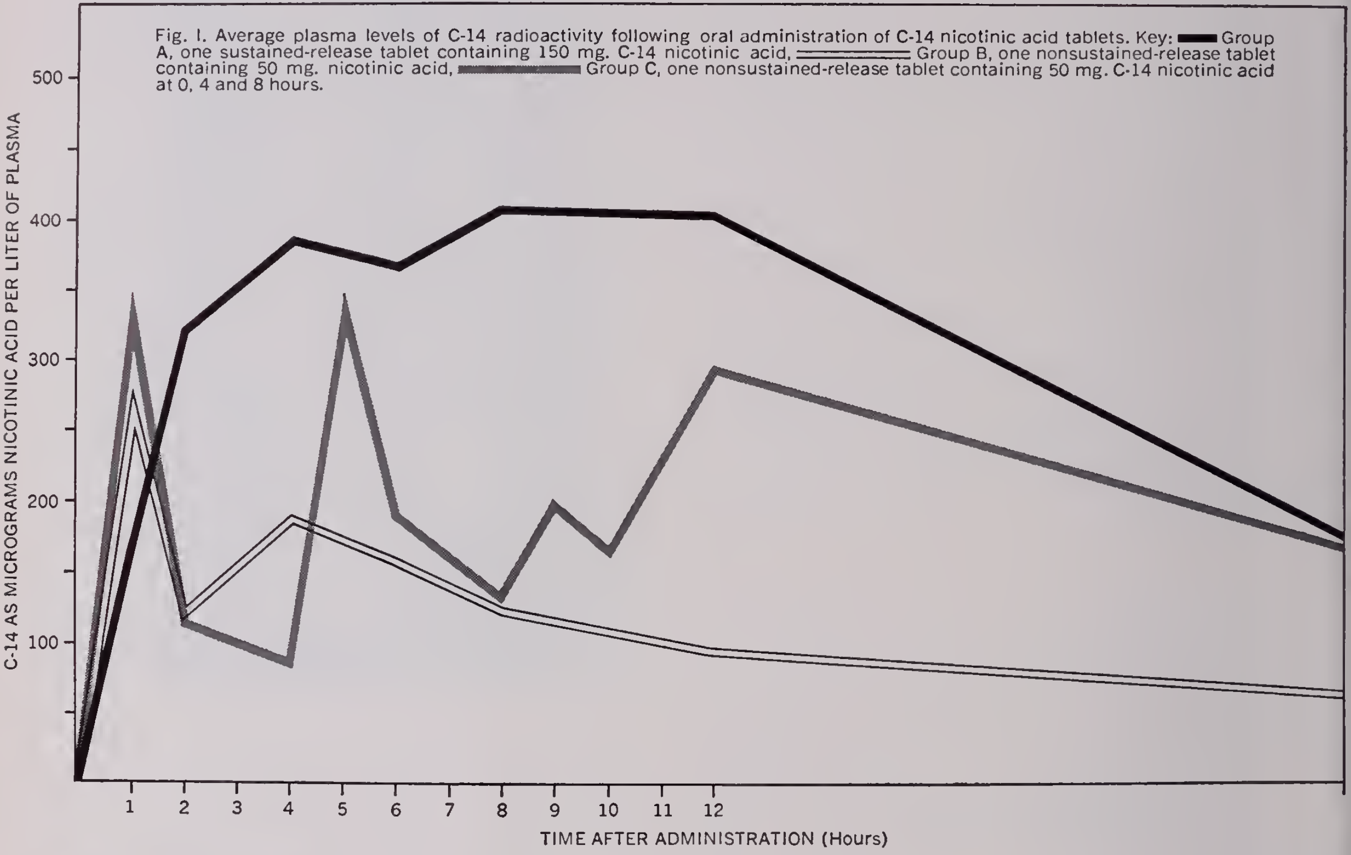

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

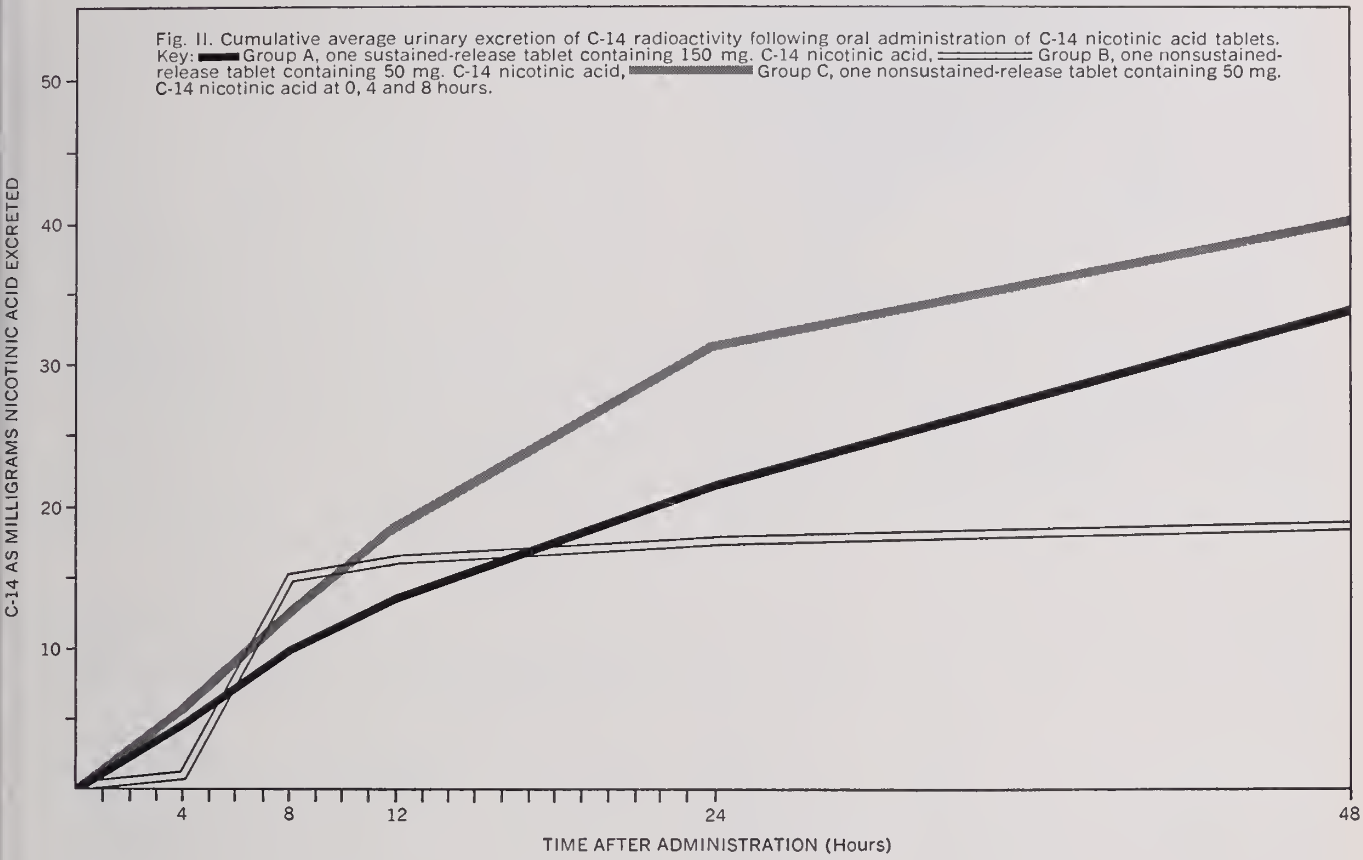

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Help Offered Physician in Reporting His Earnings for Social Security

BY: ROGER W. SEAMON,
DISTRICT MANAGER
U.S. DEPARTMENT OF HEALTH,
EDUCATION AND WELFARE
SOCIAL SECURITY
ADMINISTRATION
DISTRICT OFFICE
216 TOWNSEND STREET
LANSING, MICHIGAN 48914

Sometime between now and April 15 each of us will go through the annual ritual of "filing the income tax return." This year, for only the second time, doctors of medicine will be paying Social Security self employment tax on the net profit from their private practice of medicine. Since this is still a new matter for most physicians, there are several unanswered questions which I would like to discuss.

You report your earnings for Social Security purposes as part of your income tax return, just as other self-employed people do. To do this you use a Schedule C in addition to the usual Form 1040. (The Schedule C has a subsection, called Schedule SE, which is very important to the matter of reporting net profit for Social Security purposes. We will discuss this form later.)

The Schedule C should be used to list only income and expenses directly related to business activities covered by the Social Security Act. Therefore you should report on your Schedule C only income and expenses directly related to your private practice of medicine. In other words, it is a profit and loss statement for your business activities as a physician. Income and expenses not directly related to your practice of medicine are *not* reported on this Schedule C but are reported on other forms, e.g. Form 1040, as appropriate.

The Schedule SE is a résume for your net profit covered by Social Security. The net profit, from your private practice, up to $6600 is reported on this form, along with your name and address, your Social Security number and the amount of the self employment (Social Security) tax due on the net profit. For 1967 earnings the self employment tax rate is 6.4% or $422.40 on $6600 of earnings. Be sure that your name and Social Security number are shown correctly on the Schedule SE. (Your Social Security number and tax payer number are the same). If you have had other earnings covered by Social Security, i.e. from employment for a corporation etc., the amount of net profit subject to the self employment tax is reduced by this amount of other earnings.

The Schedule C and SE are filed with the Internal Revenue Service as part of your personal income tax return. The self employment tax is included with the income tax paid with the return. IRS reports your self employment earnings to the Social Security Administration and credits your self employment tax to the Social Security Trust Funds. No separate report nor payment need be made to the Social Security Administration.

Each year's report is recorded to your individual Social Security account. These accumulated annual earnings will determine what your benefit will be when you come to apply for benefits sometime in the future.

In the meantime we recommend that you periodically check on the amount of earnings recorded to your account in our files. We have a post card request form that you can use about every 4 years. This card is sent to the Social Security record center in Baltimore which will send you a report of the earnings recorded to your account. The report will show the total earnings accumulated in your account. In addition it will give the amount credited for each of the past 3 years. If this information is incorrect, your Social Security office will assist you in correcting our records. In this way you can insure that your earnings are properly recorded in your Social Security account.

EXHIBIT SEEKS EAR TRUMPETS

Have you found any ear trumpets lately? An ancient hearing aid, perhaps? Eh? Yes, you heard (read) correctly.

Any early hearing devices, articles used to relieve hearing problems, or early testing equipment such as tuning forks, whistles, etc., are wanted by the Kresge Hearing Research Institute at the University of Michigan.

Merle Lawrence, Director of the Institute, is establishing an historical exhibit of such devices. Persons wishing to contribute items are requested to contact him at the Institute in the University of Michigan Medical Center, 1301 Ann Street, Ann Arbor.

LEADS LENAWEE STUDY

Richard Dustin, M.D., President of the Lenawee County Medical Society, has been named chairman of a committee of doctors and laymen newly-organized to investigate the possibility of creating a county mental health board.

MSMS PR Committee Suggests Use of AMA Health Guide

Today's Health Guide, the American Medical Association's fast-selling manual of health information, has gone into its third printing, and is now available in book stores.

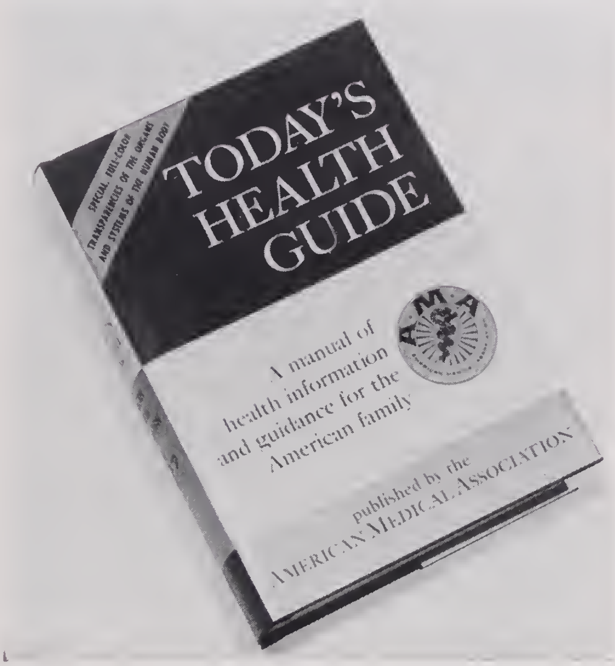
The MSMS Public Relations Committee urges component societies to distribute copies to libraries, newspapers, etc.

More than 250,000 copies have been sold.

Today's Health Guide has 90 chapters, each dealing with an important aspect of health in the family. It is illustrated by hundreds of easy-to-understand drawings, including "trans-vision," or full color "see-through" drawings, of the organs and systems of the human body.

The guide is the product of many doctors and allied scientists. More than 200 people had a role in its preparation—practicing physicians and specialists, dentists, veterinarians, clergymen, chemists, physicists, nurses, educators, engineers, safety experts, writers, reviewers, and members of the AMA staff.

Today's Health Guide is available through your bookseller or by mail order from the American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610, for $5.95. Check or money order should accompany each order.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MAILBAG

I just want to tell you how much PMA and its members appreciate the assistance of *Michigan Medicine* in publicizing our new advertising project in the *Reader's Digest.* We have been informed by our agency that you requested a plate of our "Dear Doctor" ad, to help enable your members to order packets of reprints of our *Digest* booklet to distribute to their patients.

A most gratifying number of journals have made use of the plate and I am glad to say that many hundreds of physicians have responded.

Whether the approach we have taken will be successful in informing the general public of the achievements and problems of the pharmaceutical industry remains to be seen, of course. Meanwhile, the early reaction, including your own expression of interest, has been very encouraging.

Sincerely yours,
C. Joseph Stetler, President
Pharmaceutical Manufacturers Association

Dear Doctor Lowery:

I am sure you expected some comments on your discussion of the "Dangers of Adenotonsillectomy" published in Viewpoints in the last issue. I am glad to contribute my thoughts on this important point.

There is no question but what the philosophy of the conscientious physician involved in making the decision concerning adenotonsillectomy has changed in the recent past. The T&A was often considered necessary in the growing up process. We all know that is not correct. However, to state that the "only valid criteria for adenotonsillectomy are documented recurrent ear infections with increasing hearing loss or peritonsillar abscess" seems to me to be understanding the situation a bit. There must be something to be said for the case in which multiple bouts of acute severe tonsillitis are occurring in rapid succession requiring loss of school or work time, the use of expensive medications, but most important the exposure to possible serious complications. Your criteria also does not include the rare child who has problems swallowing food because of the mechanical obstruction due to "kissing" tonsils and what can one suggest for the child who has constant mouth breathing with its side effects (other than T&A). No knowledgeable physician recommends T&A to reduce the number of undifferentiated upper respiratory infections nor to stimulate the appetite of the anorexic child or the one who is not thriving.

101 deaths out of 1,200,000 T&A's in 1964, of course, are regrettable; however, I suspect that deaths from complications of disease related to these structures and reactions to medication used in their treatment in an equal number of individuals would be more than 101.

I am in thorough agreement that unnecessary T&A's are to be condemned but I am also strong to encourage the very carefully performed adenotonsillectomy in the individual who, with little doubt, will benefit from the procedure. Let's concentrate on urging closer supervision of the postoperative period and the encouragement of absolute perfection in the anesthesia, hemostatis, recovery room supervision, and convalescent period.

Sincerely,
Dean C. Elliott, M.D.
Department of Otolaryngology
Burns Clinic Medical Center
Petoskey

The MD-PAC political workshop was quite an interesting and valuable experience. I would like to express my thanks for the invitation to attend this workshop for I feel that exposure to organized medicine is both a valuable and necessary part of any medical students education.

Thank you.

Sincerely,
James A. Ruggles
(MSU Medical Student)

I thank you again for inviting me to participate in the proceedings of the Michigan State Medical society. As an educator, I was delighted to be included in the discussion of the vital area of family life and sex education.

Your society has made positive steps in helping the people in the state of Michigan to be better informed in the area of family life and sex education. You are to be commended.

Yours very truly,
Esther D. Schulz, Ph.D.
Associate Director for
Educational Services
Sex Information and Education
Council of the U.S.

Sees Value of State Medical Journals Increasing In Future

BY GEORGE F. LULL, M.D.,
EXECUTIVE SECRETARY,
ILLINOIS MEDICAL SOCIETY

The state medical society journals, I firmly believe, will be of even greater value in the future.

Let me explain some of the reasons for my contention. The state medical society journals in coming years will provide more essential information to physicians in such areas of growing importance as socio-economics and legislation.

This is based on the presence of so many socioeconomic factors in the physician's daily practice—be he generalist or specialist. Many of these factors have political and economic import of a specific kind peculiar to the state in which the physician lives. There was very little political activity among physicians years ago, but it is different now.

WITH HUNDREDS OF bills concerning health and medical practice being introduced in our legislatures and these being compounded on the national level, the physician must be kept informed and the state journal is one medium that is very valuable for this purpose. Should adverse legislation be introduced, the doctor may have a lot of influence with his local representative or Congressman in explaining why such legislation should not be made into law. To do this the doctor must be informed and the journal can do a good job in keeping the physician informed.

When legislation is passed it often has to be explained to society members and there the journals can go into high gear. When the recent Medicare bill became law, its administration differed in the various states, however, no state knew just how to start without guidelines and the law was operative before the details were furnished from Washington. Many questions arose about fees and the members of the state society had to be told what negotiating with the department of public aid had resulted in the way of answers. Medical details in each state had to be explained in the state medical journals.

Let me suggest several other reasons why state medical journals are important.

THE STATE JOURNALS in some instances may be a good training ground for young writers. These men may have scientific articles, book reviews, even editorials that are worthwhile. They need only a little encouragement and this may be of a great deal of importance in their development.

The physician, as a rule, is interested in what happens to his colleagues in the state,—who died, who was elected to office, who was given an award, etc. There is no better place for this material except in his state journal. These items take up little space, but a large percentage of the readers look for them first.

The state journal can be of a great deal of service as an historical document. It is surprising how many important facts, some more so than others, are lost.

AS I LOOK AT THE state medical journal, it is my opinion that it was of much more value to the members in the past than it is at present. However, I visualize the time in the near future when it will be of a great deal more value. I am convinced that the state medical journal definitely deserves a place in the overall field of medical journalism.

I am sure that there will be a need for some kind of professional journal either for each state or for a group of states for a long time in the future.

BOOK REVIEWS

DEVELOPMENT OF THE LUNG, CIBA FOUNDATION SYMPOSIUM. Edited by A.V.S. De Reuck and Ruth Porter. $13.00 Little, Brown and Company, Boston, 1967.

This book is based on a symposium held in London on November 1st to 3rd, 1965. Its members were twenty-five distinguished pediatricians, physiologists, anatomists, biochemists, physical chemists, and zoologists from varying parts of Europe and the U.S.A. The purpose of the symposium was to explore the physiological problems that animals faced in the development of the lung when they evolved from water to air breathing and to relate these to the problems of the human fetus as it progresses from liquid filled lungs to air breathing at birth. It is an unique approach, and although the analogy may be a bit obscure, there is much to recommend this book.

The symposium consisted of eighteen presentations, each followed by a discussion from the entire group. It starts with a discussion of gas transport between the environment and cell and includes an interesting discussion of changes in pH with changes in temperature of the animal. The concept is presented of [OH —]/[H +] constancy as an explanation for the increase in arterial pH with decrease in temperature. In subsequent presentations there are discussions of the changes in respiratory function as animals moved from water breathing to air breathing. It is interesting that in amphibians the skin seems to have an important function in removing CO_2. The embryology, postnatal development and alveolar surface lining layer of the lung are described. In this section are some interesting electron micrographs. Intrauterine gas exchange is then considered. Some contributors noted that the O_2 affinity of fetal hemoglobin is little or no different from maternal hemoglobin. The previously reported differences were felt to be due to pH effect. The initiation of respiration, the pulmonary circulation in the fetus and new born, and the uptake of liquid from the lungs at birth are next discussed. Data are presented suggesting that much of the lung liquid in the lamb is removed by the lymphatics with the onset of respiration.

The discussions following each presentation are well edited and bring up many fascinating subjects. For example, the question is raised whether chickens can hatch at high altitude because of the limitation of O_2 diffusion through the shell. The conclusion seems to be that adaptive mechanisms have allowed chickens to be born at high altitudes but that eggs will not hatch following abrupt change from low to high altitudes. Another interesting discussion is concerned with oxygen consumption in diving seals.

This book is well worth reading and should be of interest to pulmonary physiologists and neonatologists or anybody with curiosity about respiratory development and adaptation.

William F. Howatt, M.D.
Associate Professor of Pediatrics
University of Michigan
Ann Arbor, Michigan

DIABETES MELLITUS: DIAGNOSIS AND TREATMENT, VOLUME II. Edited by George J. Hamwi and T. S. Danowski. 250 pp. $2.50 American Diabetes Association, Inc., New York, 1967.

The first volume of *Diabetes Mellitus: Diagnosis and Treatment* was published in 1964. It was stated that this was an effort to provide practical, concise and up to date information to a large number of physicians. The second volume contains many new titles as well as authors not found in the first volume. Quite correctly, one can state that each complements the other with a minimum amount of duplication.

One of the strongest features of this very excellent book is the brevity with which the authors have been able to convey a great deal of information. Both editors and authors are to be congratulated for being able to cover their subjects in chapters that average about five pages each. Some of the titles of the chapters indicate the range of this new volume. The following are examples: Recent Research Interests in Diabetes, The Genetics of Diabetes Mellitus, A Differential Diagnosis of Hyperglycemic States, The Clinical Use of the Various Insulins, and Pregnancy and Diabetes Mellitus. There are a total of forty-two chapters in the text. It would be difficult to single out any one of them as being superior to others. Two sections of the book which probably will be found very helpful to the practicing physician are entitled, Emergencies and Long Term Problems. These are covered in much greater detail than in the first volume published three years ago.

The authors frequently express their own personal philosophies concerning the approach to a particular problem. In most instances the reason for a particular approach is very well outlined. In a book of such brevity, alternate courses obviously could not be given in much detail. This reviewer, however, felt that this was not truly a fault of the text since it is primarily designed for the non-specialist in the field of diabetes mellitus.

I would emphasize, however, that the specialist can use this text to his benefit as a quick review and an accurate presentation of our present knowledge in this field.

Finally, the publishers are to be congratulated on making the volume available at such an inexpensive price. In spite of this, the book is well constructed, contains adequate references at the ends of most chapters and has a very complex index. It can be highly recommended.

George H. Lowrey, M.D.

NEW BOOK ON ALCOHOLISM AVAILABLE FROM AMA

The new Manual on Alcoholism has been published by the American Medical Association and provides practical medical guidelines.

In 87 pages, the AMA's new manual defines alcoholism and sets out its causes. It tells what an alcoholic is and is not, and what physicians can do to help him.

Thirteen authorities submitted resource information for the manual, which was edited by Robert J. Shearer, M.D., former associate director of the AMA Department of Mental Health, and approved by the AMA Council on Mental Health and its Committee on Alcoholism and Drug Dependence.

The manual is available from the Order Handling Unit, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610. Prices are 50 cents a copy in the U.S., its possessions, Mexico, and Canada (40 cents a copy for medical students, interns and residents in those countries), and 60 cents in all other countries.

MSMS BOOKLET DISPLAYED AT AMA INSTITUTE

Among the publications on display at the AMA Communications Institute was the MSMS booklet *"The American Economic Scene at Mid-Century."* The publication is a collection of socio-economic articles, originally published in *Michigan Medicine.* Articles were written by Clyde T. Hardwick, Ph.D., who is the economic consultant to MSMS. Professor Hardwick is Associate Dean of the College of Commerce at The University of Detroit.

Copies of the 18-page booklet are available from MSMS, 120 West Saginaw, East Lansing 48823.

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IN MEMORIAM

L. R. Atler, M.D., Detroit

Lawrence R. Atler, M.D., Detroit physician, died November 14 at the age of 68. He had practiced medicine in Detroit for 40 years.

Born in Detroit, he was graduated from the Detroit College of Medicine in 1926. Doctor Atler was affiliated with Grace Central Hospital.

He was a member of the Intercollegiate Club of Detroit and Phi Delta Epsilon medical fraternity.

Oliver W. Lohr, M.D., Saginaw

Oliver W. Lohr, M.D., noted Saginaw pathologist, died October 25. He was 73.

Doctor Lohr was born in Pittsburgh, Pennsylvania, attended high school in Berrien Springs, and received his M.D. degree at Washington University, St. Louis, Missouri, in 1921. During World War I he served at the Base Hospital, Rouen, France.

The first pathologist in the Saginaw Valley, he started out serving all three area hospitals and was pathology chief for many years at St. Mary's Hospital, Saginaw, until 1957. He was also affiliated with the Saginaw Veterans Hospital. He opened his own Central Laboratory in 1922 and operated it until 1961.

Doctor Lohr was a past president of the Saginaw County Medical Society and a Life Member of MSMS. He was once president of the Michigan Pathological Society and was a member of the American Society of Clinical Pathologists, the American College of Physicians, the American Heart Association, the American Public Health Association and the American Cancer Society. His medical fraternity was Alpha Omega Alpha.

Active in cultural affairs, he had been president of the Community Concert Association. He was also a past president of the Saginaw Valley Torch Club and a leader in the Rotary Club.

One of the survivors is his son, Thomas O. Lohr, M.D., of Saginaw.

E. E. Poos, M.D., Detroit

Edgar E. Poos, M.D., Detroit eye, ear, nose and throat surgeon, died September 22 at the age of 73.

Doctor Poos received his M.D. degree from St. Louis University, having done his pre-medical work at McKendree College, Lebanon, Illinois.

During World War I he attained the rank of Lieutenant Colonel as a medical officer. Following his internship and residency in otolaryngology at St. Louis City Hospital, St. Louis, Missouri, he began practice in Detroit.

He was a Life Member of the Wayne State Medical Society, Michigan State Medical Society, American Medical Society, Board of Otolaryngology, American College of Surgeons, International College of Surgeons, and Masons, and held fellowships in several other professional organizations. He was a graduate flight surgeon and examiner for United Airlines.

Postgraduate studies and clinics took him to Vienna, London, Bordeaux, Montpelier, New York, St. Louis, Chicago, Cincinnati, Boston, Indianapolis, Ann Arbor and Detroit.

He was affiliated with Highland Park General Hospital, Mt. Carmel Mercy Hospital, Grace Hospital, Hutzel Hospital and Detroit General Hospital.

E. C. Sites, M.D., Port Huron

Edgar C. Sites, M.D., Port Huron surgeon and civic leader, died November 7 of injuries received in an automobile accident. He was 75.

Graduated from Valparaiso University in 1915 with an A.B. degree, he entered the teaching profession. He was a school principal in Francesville, Indiana, until World War I, during which he served in the U.S. Army, rising to the rank of captain.

After the war, he entered Indiana University Medical School and received his M.D. degree, cum laude, in 1923. He spent another year at Indiana University doing postgraduate research. His internship and further studies were done at Henry Ford Hospital in Detroit. In 1927 he moved to Port Huron where he practiced for the past forty years. He was to retire the week of his death.

For the past 16 years, he was president of the St. Clair County Health Department. He was the first chief of staff of Mercy Hospital, which he helped establish and continued to serve as a member of the Advisory Board. He had also been chief of staff of the Port Huron Hospital.

A past president of the St. Clair Medical Society, he was honored in 1959 by fellow physicians for his contributions to the advancement of medicine in the area, his promotion of annual clinic days and his assistance to young doctors beginning practice.

Doctor Sites was a member of the Port Huron District Foundation and of the St. Clair County

Community College Foundation, and had recently received a pin for 18 years of perfect attendance from the Port Huron Rotary Club.

He was a Fellow of the American College of Surgeons and a regent of the Midwest Area of the Fellowship of the International College of Surgeons. He was a member of the Society of Abdominal Surgeons and Alpha Omega Alpha and Phi Chi medical fraternities.

C. G. Wencke, M.D., Battle Creek

Carl G. Wencke, M.D., retired Battle Creek otolaryngologist, died November 11 at the age of 78. He had practiced in Battle Creek for 50 years.

Born in Lawrenceberg, Indiana, he attended the former American Medical Missionary College in Battle Creek for two years and completed his M.D. degree at the University of Illinois in 1914. After graduation he returned to Battle Creek and joined the staff of the Battle Creek Sanitarium Hospital where he remained until 1936, interrupted only by service in World War I and by postgraduate study at the University of Illinois, the University of Pennsylvania in 1921-22, and the University of Vienna, Austria, in 1926. He headed the ENT department of the hospital from 1930 to 1936. In 1936, he opened private practice which he continued until his retirement in 1964. In that year, he was awarded a 50-year service pin from the Michigan State Medical Society.

Doctor Wencke was a charter member of the U.S. Army Ambulance Service, having served from 1917-1919 in an ambulance company in Italy. In the Army, he rose to the rank of captain and was decorated by the Italian government with the Cavalier Award.

He served as president of the Southwestern Michigan Trilogical Society in 1938. A past president of the Calhoun County Medical Society and a Life Member of MSMS, Doctor Wencke was a member of the American Academy of Otolaryngology and a Fellow of the American Otorhinologic Society for Plastic and Reconstructive Surgery and the American College of Surgeons. He was a past president of the Battle Creek Kiwanis Club and a 32nd degree Mason.

D. R. Wright, M.D., Flint

Donald R. Wright, M.D., Flint, former president of the American Proctology Society, died November 17, He was 72.

A 1923 graduate of the University of Michigan Medical School, he began practice in Flint in 1924. He had served during World War I in France at Base Hospital #17, AEF.

Doctor Wright was a former president of the Genesee County Medical Society, the Flint Academy of Surgery and the American Proctology Society. He was an honorary member of Galeas and a member of Phi Chi medical fraternity.

He was a past president of the Flint Downtown Optimist Club and a member of the U-M Club of Flint, the U-M Alumni Association, the Elks, and Lakeside Lodge 371, F&AM.

Midland policemen and firemen watch a demonstration in the correct use of the respirator.

NEW ARTIFICIAL RESPIRATORS IN USE AT MIDLAND

"If these units save one life in five years, they will be well worth the cost," commented Sidney Smock, M.D., anesthesiologist at Midland Hospital, during a recent training session for City employees in the use of a new kind of artificial respirator.

Midland has purchased 23 of the simply-constructed, breathing aids for emergency use in public places. They have been placed in police cars and fire trucks and other city vehicles, and plans call for putting them in ambulances, public school gymnasiums, swimming pools, and doctor's offices.

"Completely safe for any individual, there is no device more effective for artificial respiration," doctor Smock said.

The respirator is useful whenever a person is not breathing, or not breathing properly. Doctor Smock points out that the unit, which uses natural air, will be useful in most emergency situations except for smoke inhalation and gas contaminated air cases when pure oxygen is needed.

Roy M. Goethe, M.D., president of the Midland County Medical Society, praised the resuscitators because they are "small, convenient, and spread all over town for immediate use." "Wherever they have been placed," Doctor Goethe added, "the people in charge have been trained to use them by a physician."

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> American Farm Bureau

Offer International Vaccination Memo:

An advisory memorandum on International Certificates of Vaccination has been issued by the Michigan Department of Public Health and will be of interest to MSMS members.

The MDPH memorandum quotes the Chief, Epidemiology and Research Analysis Section, Foreign Quarantine Program, U. S. Department of Health, Education and Welfare, National Communicable Disease Center, Atlanta, Georgia. It states:

"The Committee on International Quarantine in its Third Report (Official Records of the World Health Organization—No. 72, page 49) made several recommendations to answer certain questions referred or sumbitted to the World Health Organization in respect to the International Certificates of Vaccination. Because of the frequency of similar questions, you may find the Committee's statements helpful.

"(1) Only qualified medical practitioners should sign vaccination certificates.

"(2) Vaccinations may be carried out by nurses and medical technicians if under the direct supervision of a qualified medical practitioner.

"(3) A medical practitioner is required to sign the certificate in his own handwriting; his official stamp is not an accepted substitute for his signature.

"(4) As indicated in Appendix 4 (of the International Sanitary Regulations), the result of a primary smallpox vaccination must be recorded.

"(5) When a baby born to a mother immunized against smallpox has an unsuccessful primary vaccination, the unsuccessful result should be recorded.

"(6) A parent or guardian should sign the international certificate of vaccination when the child is unable to write. The signature of an illiterate should be indicated in the usual manner by his mark and the indication by another that this is the mark of the individual."

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage
3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*

He's on the wagon...an

How well does Vistaril relieve the symptoms that plague an alcoholic during the recovery period? Doctors Knott and Beard of the Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital and Institute, recently conducted a double-blind study comparing Vistaril and another well-established antianxiety agent with placebo in 60 chronic alcoholic patients.[1]

The investigators conclude: "It was the opinion of the staff that hydroxyzine was generally more effective than chlordiazepoxide, for the following reasons: hydroxyzine was equally if not more effective in reducing anxiety and tension and it produced less daytime sedation...."[1] (See results on succeeding pages.)

Here is new evidence that Vistaril can ease tension, allay anxiety in chronic, hospitalized alcoholic patients. *But you might also choose Vistaril for what it doesn't do.* Although not evaluated in this study, Vistaril is reported to be non-euphoriant, and its low toxicity makes it relatively safe. Best of all, Vistaril is non-habituating. To date, after more than ten years of clinical use, there have been no reports of dependency in patients receiving Vistaril.

With Vistaril, it is as easy to stop therapy as it is to start.

Vistaril®
(HYDROXYZINE PAMOATE)

PLEASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

SYMPTOM RATING KEY

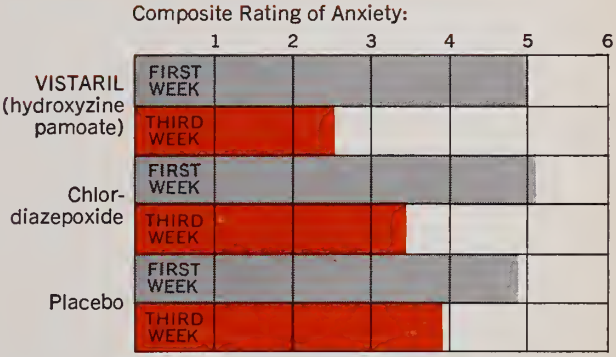
1=Not Present	4=Moderately Severe
2=Mild	5=Severe
3=Moderate	6=Extremely Severe

The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results[1] ▨ DURING FIRST WEEK 🟥 DURING THIRD WEEK

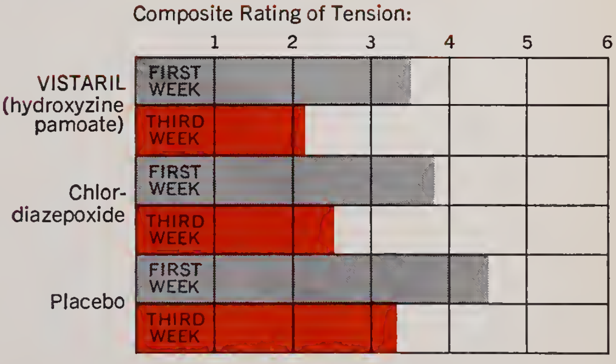
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
50%	33%	20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
40%	34%	27%

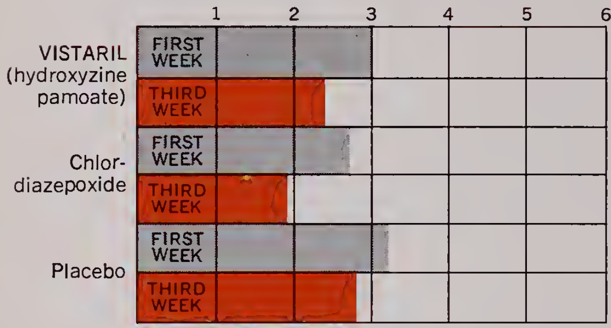
In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

▨ DURING FIRST WEEK 🟥 DURING THIRD WEEK

Depressive mood improved with chlordiazepoxide

Composite Rating of Depression:

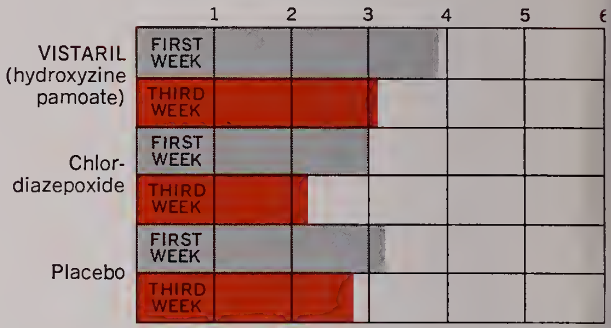


OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
20%	30%	13%

Emotional withdrawal counter-acted with chlordiazepoxide

Composite Rating of Emotional Withdrawal:

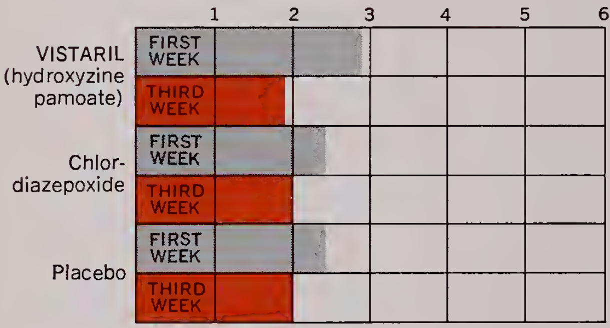


OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
21%	27%	13%

Guilt feelings allayed with Vistaril

Composite Rating of Guilt Feelings:

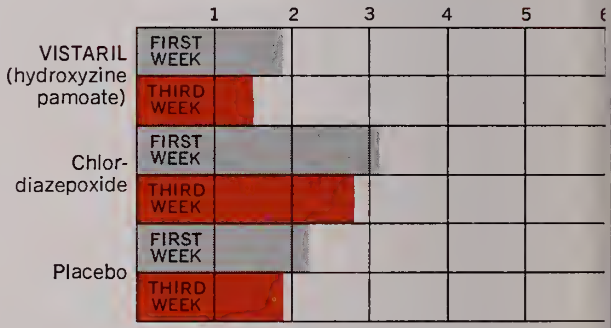


OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
34%	17%	17%

Somatic concern alleviated to minor degree in each group

Composite Rating of Somatic Concern:



OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

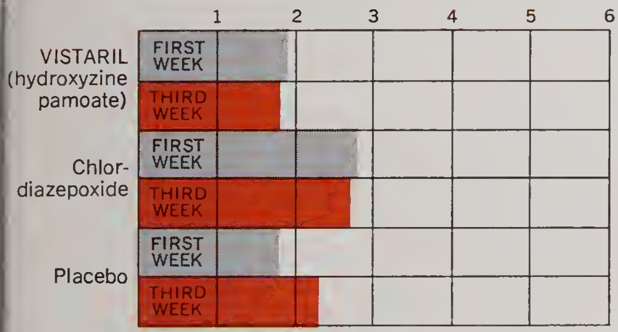
VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
17%	13%	14%

Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treated
Chlor-diazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treated
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treated

Increase in hostility minimized with Vistaril and chlordiazepoxide

Composite Rating of Hostility:

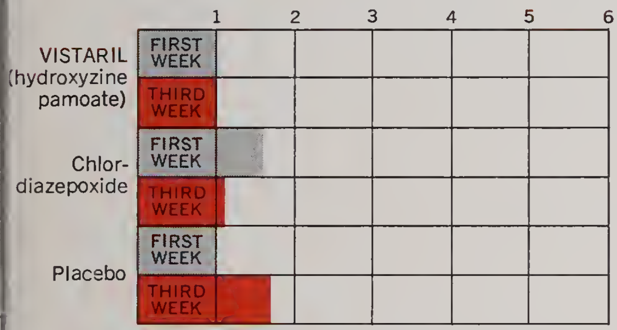


OVERALL CHANGE IN HOSTILITY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
5%	4%	—28%

Cooperativeness not a significant problem

Composite Rating of Uncooperativeness:



OVERALL CHANGES IN COOPERATIVENESS (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
No change	31%	—70%

In Alcoholism...

Vistaril®

(HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly peri-arterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Night Leg Cramps... Unwelcome Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now ... specific therapy for night leg cramps

Walker
QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

VOLUME 67, JANUARY 1968, NUMBER 2 — NEWS EXTRA — DEADLINE JANUARY 10

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

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OF PHILADELPHIA
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Expect 75-80 New Bills To Bear on Medical Practice

BY M. A. RILEY
MSMS LEGISLATIVE REPRESENTATIVE

In this Michigan State Senate chamber, shown below, and in the Hall of the House of Representatives in the opposite wing of the second floor of Michigan's State Capitol Building, the second regular session of the 74th Legislature of the State of Michigan is now underway.

Thirty-eight State Senators and 110 State Representatives will during the next four or five months consider well in excess of 1,500 individual legislative proposals. If the "form book" is followed, 75 to 80 of these will have a very direct bearing on the practice of medicine.

Bills which were first introduced in the first of the 74th Legislature's two sessions (1967) and which were not disposed of last year are still eligible for consideration during 1968, and these coupled with an expected large volume of new proposals for laws assure that the Spring will be a busy time indeed for MSMS' Legal Affairs Committee.

The Society, exclusive of new bills which will be making their appearance in the next few weeks, has a vital interest in sixty-two bills still unresolved when the first session ended in December of 1967.

Seventeen of the 62 bills being "followed" by MSMS are endorsed by the Society and form a positive program of good legislation which is being vigorously supported for passage. On the other hand, twenty-four of the bills introduced during 1967 were considered as not in the best health interest of the people and continue to be opposed by MSMS. The remaining twenty-one proposals continue to be closely observed but as yet have not been classified "support" or "oppose," inasmuch as they have received no action as yet and are subject to change during the legislative process.

It is likely that an additional thirty or more health bills will be added to the 62 before mid-March. Very soon after the distribution of this issue of *Michigan Medicine* the MSMS Legal Affairs Committee will again commence issuing regular "Medigrams," reporting currently on the content of all new health legislation and the progress of bills left over from 1967.

The "Medigram" is mailed to all those members who have expressed a particular personal interest in Legislative matters and who have indicated their willingness to convey their opinions to their personal representatives in the Legislature. Anyone desiring to receive "Medigram" need only correspond with the MSMS Legal Affairs Committee at the Society's East Lansing Headquarters and ask that his name be placed on the mailing list.

Save These Blue Pages For Legislative Use Later

This "News Extra" issue of *Michigan Medicine* constitutes a Special 1968 Legislative Supplement.

Michigan Medicine readers are urged to retain these blue pages in a convenient place for easy future reference.

Participate in New February Conferences - See Back Page

Urge Passage of 17 Bills Still Eligible for Approval

The Michigan State Medical Society favors, and urges passage of, seventeen bills introduced during the 1967 session and not adopted then but still eligible for approval in 1968. Additional new proposals are expected early in 1968 which will be vigorously supported as being progressive and beneficial to the people of Michigan.

Two of these bills have already moved to the final stages of passage, having been approved by both the House and Senate but in slightly different form. When this occurs the bills are considered by a "conference committee" of Senators and Representatives with a view to resolving the differences. These are Senate Bill (SB) 479, introduced by Sen. Sander Levin and others, to further expand the medical examiner system in place of the coroner system, and SB 16, by Sen. Raymond Dzendzel and others, to provide for the licensing of hospitals.

BOTH SB 479 AND SB 16 were endorsed by MSMS from their introduction, and both received certain amendments during the legislative process which had been requested by MSMS to strengthen the proposals. It is hoped that the conference committees will be able to resolve slight inter-house differences early during 1968 and present these bills to the Governor. (The Michigan State Medical Society has also favored House Bill (HB) 2028, introduced by Rep. Thomas Sharpe and others, which parallels SB 16 regarding hospital licensing and, should SB 16 fail, would turn its support to the House measure).

SB 229, introduced at MSMS' request to repeal the Basic Science Law, is also a major part of the Society's positive legislative program. This bill has already passed the State Senate and is presently in a House of Representatives committee for study. A separate story regarding this bill will be found in this section.

HB 2900, endorsed by MSMS, was introduced by Rep. James Farnsworth and others to provide that nursing homes in Michigan will be paid reasonable charges for services rendered. This language would then parallel that pertaining to reimbursement of physicians and hospitals under the Medicare and Medicaid programs. The bill, already passed by the House, is in a Senate Committee. MSMS also is in support of SB 421, introduced by Sen. John Toepp, which would permit the operation of extended care facilities in connection with county hospitals established under the County Hospital Act. These hospitals are already permitted to operate nursing home facilities. The bill is still in a Senate Committee.

OTHER SENATE BILLS favored for passage are SB 275, introduced at MSMS' request by Sen. George Fitzgerald and others to re-create a State Commission of Mental Health with policy-making authority; SB 366 introduced by the same group of Senators to create a policy-making State Board of Public Health; and Senator Levin's SB 634, which would allow the State Board of Education to receive gifts other than real property and provide that in receiving such gifts the State would not be committed to expend funds not appropriated by the Legislature.

MSMS has vigorously supported passage of HB 2378, a proposal for a new laboratory licensing law, and has worked with several groups and the Michigan Department of Public Health to revise the proposal as originally submitted so that it enjoys the endorsement of all affected groups.

IN ADDITION, MSMS has asked for favorable action on several other House bills, all of which are still under consideration in House of Representatives Committees: HB 2151, by Rep. Jack Faxon and Rep. Bill Hayward, would create a medical evaluation board to assist Michigan's Secretary of State with driver licensing; HB 2669, by Rep. Bill Jowett and others, would require specific professional qualifications for the person serving as Michigan Director of Public Health; HB 3013, by Rep. Don Bishop, would permit the selling of duplicate eyeglasses to replace broken lenses (at present such action would constitute the practice of optometry — a person would have to obtain a prescription); HB 3031, by Rep. James Karoub and others, which would make it clear that a Medicare patient can legally receive pharmaceutical services from a licensed physician or licensed dentist (whether or not an "emergency" exists); HB 2586, by Rep. Peter Kok and others, which would spell out qualifications for the post of State Director of Mental Health; HB 3120 by Rep. Bill Ryan, to provide for payment of reasonable charges to physicians for services rendered to afflicted children; and HB 3120 by Rep. Tom Sharpe and Rep. Tom Ford which would establish a medical advisory committee to assist the Director of the Michigan Workmen's Compensation Department.

Reports on the progress of all of these bills favored by MSMS will be regularly made via "Medigram" and in the pages of *Michigan Medicine* as the session progresses.

Seek to Negate IRS Decision Re Ad Income; Write to Griffiths

The federal Internal Revenue Service has recently adopted an administrative regulation under which, for the first time, tax will be levied on the income derived by organizations from what are held to be "unrelated activities." This regulation would strike directly at the income received from advertising in the journals of a wide variety of organizations, income which in many instances makes possible the publication of such organs.

It is essential that all possible haste be made in making all possible representations to the members of the U.S. House of Representatives on this matter, which is vitally important to many organizations including your American Medical Association and Michigan State Medical Society.

Bills had been introduced in Congress during 1967 to prevent the adoption of such a regulation by a bureau of the federal government, but before the Congress had sufficient opportunity to consider the bills the regulation was adopted. It would seriously hamper the activities of organizations publishing scientific journals, chambers of commerce, such organizations as the Boy Scouts, etc.

In the immediate wake of this action by Internal Revenue four (4) separate bills have been readied for introduction in Congress on January 15, 1968 all of which would negate the new regulation. It is extremely important that the Ways and Means Committee of the U.S. House of Representatives in Washington, D.C., conducts immediate hearings based on these four bills and the new IRS regulations.

Michigan has one member of the 25-member Ways and Means Committee, Hon. Martha W. Griffiths of Detroit. Every interested and concerned doctor of medicine in Michigan should immediately and urgently request Congresswoman Griffiths to support the holding of hearings immediately after Congress gets underway.

CONTACT ALL CONGRESSMEN

Secondly, all physicians are urged to ask their own individual congressmen to use their good offices to urge hearings by the House Ways and Means Committee; this may be done through respectfully suggesting to them that they speak with Congresswoman Griffiths, or that they discuss the matter with *other* members of the Ways and Means Committee with whom they are well acquainted.

CONTACT OTHER INVOLVED GROUPS

Finally, and very importantly, all physicians are urged to discuss the possible impact of this new IRS regulation with other groups. It affects all charitable, educational, and scientific organizations. It affects not only revenue derived from advertising in their publications, but also from sale of exhibits at meetings—taxing such income at a corporate rate of 48%!

Any non-profit organization should be alerted to take a careful look at this new IRS regulation which can seriously affect its tax picture. Physicians will be doing such organizations a real service by inviting this matter to their attention immediately: by exact reference, the new regulation is *new section* 1.513-1 of Chapter 1, Part 1 of the Internal Revenue Code.

Support MYC Efforts To Amend State Law Re Sex Education

The law of the State of Michigan presently dealing with instruction and training in health and physical education expressly prohibits any person to offer any advice or information with respect to birth control. The same section of the School Code also provides that any child presenting a written request from a parent or guardian must be excused from instruction in sex hygiene or the symptoms of disease.

The Michigan Youth Commission, feeling that these provisions of law are grossly inadequate today, has been in the process of preparing amendments for introduction in the 1968 session of the Michigan Legislature. The Council of the Michigan State Medical Society has adopted a policy calling for amendment to the current law to permit meaningful "family life education" in Michigan's schools.

MSMS members have been working for several months with the Michigan Youth Commission and the MSMS Maternal Health Committee itself has also been involved as a resource group to the Commission. Proposed changes in the present statutes are now being reviewed by the MSMS Legal Affairs Committee, and will be reported on in detail in future issues of "Medigram."

February Conferences Info on Back Page

MSMS leaders and interested members will study many complex issues about the distribution of medical care at new conferences, February 22-23-24 in Detroit.

See back page for some details. Watch mail for registration form. Block out days now.

1968 Key Health Committees In State Legislature; Please Save

The bulk of health-oriented legislation is referred by the Lieutenant Governor (in the State Senate) and the Speaker of the House of Representatives to one of the following committees for study when introduced. Similarly when a Senate bill passes to the House, or vice versa, it will go in the first instance to one of these committees for preliminary analysis in the second chamber.

In order that this may be illustrated those bills from 1967 which have carried over to the 1968 session are listed below each committee:

SENATE COMMITTEES

HEALTH AND WELFARE COMMITTEE

Lorraine Beebe (R) Dearborn, Chairman
Harry A. DeMaso (R) Battle Creek, Vice Chairman
George Kuhn (R) Birmingham
George S. Fitzgerald (D) Grosse Pointe Park
Arthur Cartwright (D) Detroit

(No bills at present, but gets mental health, hospital licensing and crippled children bills, for example)

STATE AFFAIRS COMMITTEE

Thomas Schweigert (R) Petoskey, Chairman
Robert Huber (R) Troy in Oakland County
Michael O'Brien (D) Detroit
Charles Youngblood (D) Detroit
VICE CHAIRMAN VACANCY WILL BE FILLED IN MID-JANUARY

(SB 275, SB 366; all bills affecting licensing laws)

JUDICIARY COMMITTEE

Robert Richardson (R) Saginaw, Chairman
Harvey Lodge (R) Waterford in Oakland County, Vice Chairman
James Fleming (R) Jackson
Basil Brown (D) Detroit
Roger Craig (D) Dearborn

(Abortion bill is here; also ambulance licensing, medical examiner bills)

APPROPRIATIONS

Frank Beadle (R) St. Clair, Chairman
Charles Zollar (D) Benton Harbor, Vice Chairman
Milton Zaagman (R) Grand Rapids
John Toepp (R) Cadillac
Harold Hungerford (R) Lansing
Garland Lane (D) Flint
Joseph Mack (D) Ironwood
Jerome Hart (D) Saginaw

(SB 634, HB2900; all bills involving expenditures)

HOUSE COMMITTEES

SOCIAL AID AND WELFARE

Joe Kolderman (R) Wyoming in Kent County, Chairman
Robert Mahoney (D) Detroit, Vice Chairman
Allen Rush, (R) Lake Orion in Oakland County
Thomas Sharpe (R) Howell
Lionel Stacey (R) Benton Harbor
Philip Pittenger (R) Lansing
Rosetta Ferguson (D) Detroit
Matthew McNeely (D) Detroit
Edward Suski (D) Flint

(HB 3031; gets bills involving Medicare-Medicaid)

PUBLIC HEALTH

Blair Woodman (R) Owosso, Chairman
Dale Kildee (D) Flint, Vice Chairman
Fred Marshall (R) Allen in Hillsdale County
William Jowett (R) Port Huron
Carl Little (R) Saginaw
Edson Root (R) Bangor in Van Buren County
Stanley Davis (D) Grand Rapids
Lucille McCollough (D) Dearborn
Daniel Cooper (D) Oak Park

(HB 2028, HB 2669, HB 3013; all optometry bills are here)

MENTAL HEALTH

Peter Kok (R) Grand Rapids, Chairman
Joyce Symons (D) Allen Park in Wayne County, Vice Chairman
James Folks (R) Horton in Jackson County
Loren Anderson (R) Pontiac
Lionel Stacey (R) Benton Harbor
Russell Strange (R) Mt. Pleasant
Jack Faxon (D) Detroit
Raymond Hood (D) Detroit
Joseph Snyder (D) St. Clair Shores

(HB 2586, SB 506)

STATE AFFAIRS

Thomas Sharpe (R) Howell, Chairman
Robert Davis (R) St. Ignace, Vice Chairman
Fred Marshall (R) Allen in Hillsdale County
Peter Kok (R) Grand Rapids
Harold Stevens (R) Detroit

CONTINUED: 1968 Key Health Committees in Legislature

DeForrest Strang (R) Sturgis in St. Joseph County
Nelson Tisdale (R) Midland
James Del Rio (D) Detroit
Josephine Hunsinger (D) Detroit
Dominic Jacobetti (D) Negaunee
Albert Kramer (D) Oak Park
Vincent Petitpren (D) Wayne
Thomas White (D) Detroit

(SB 227, SB 229; osteopathic, optometric, other licensing bills)

APPROPRIATIONS

Arnell Engstrom (R) Traverse City, Chairman
Cyril Root (R) Kalamazoo, Vice Chairman
Charles Davis (R) Onondaga in Ingham County
James Farnsworth (R) Plainwell in Allegan County
Thomas Ford (R) Grand Rapids
Donald Bishop (R) Rochester in Oakland County
Roy Smith (R) Ypsilanti
Charles Varnum (R) Manistique
William Copeland (D) Wyandotte
Russell Hellman (D) Dollar Bay in Houghton County
Arthur Law (D) Pontiac
George F. Montgomery (D) Detroit
William Ryab (D) Detroit

(HB 3130, HB 2378)

JUDICIARY

Donald Holbrook (R) Clare, Chairman
Thomas Brown (R) Lansing, Vice Chairman
Joseph Swallow (R) Alpena
Dennis Cawthorne (R) Manistee
Edgar Geerlings (R) Muskegon
William Weber (R) Kalamazoo
Hal Ziegler (R) Jackson
Harold Clark (D) Warren in Macomb County
Daniel Cooper (D) Oak Park
Dale Kildee (D) Flint
Michael Novak (D) Detroit
James O'Neill (D) Saginaw
Bob Traxler (D) Bay City

(Medical examiner, implied consent, etc. legislation)

BILL TO REPEAL BASIC SCIENCE LAW NEEDS HOUSE VOTE

For several years MSMS has sponsored legislation to repeal the Basic Science Law enacted in Michigan in 1937. During the 1966 legislative session the House of Representatives voted to repeal this outmoded law, but the State Senate did not act. During the 1967 legislative session the State Senate voted to repeal Basic Science, but the House, instead of repeating its earlier action, sent the bill (SB 229) to the State Affairs Committee for "further study" along with the proposed chiropractic measure.

SB 229, now held in the House State Affairs Committee, is therefore already through the State Senate and needs only House action to become law. If reported for vote it will be before a House of Representatives which, two years ago, endorsed it by a vote of exactly 100-0!

Michigan's Department of Licensing and Regulation, which incorporated the Basic Science Board after governmental reorganization, has joined with MSMS in pleading with the Legislature to repeal the law. Repeal also has the endorsement of the Executive branch of state government; it has been repeatedly urged upon the legislature by Michigan's leading medical educators.

AS THE LAW PRESENTLY stands, physicians who wish to come to Michigan to practice must, unless they have taken a basic science examination in another state, submit to such a test *before* being examined *in the same subjects* by the State Board of Registration in Medicine. Many physicians have declined to practice in Michigan because of this unrealistic hurdle.

Under the law doctors of medicine, doctors of osteopathy, and chiropractors must all meet basic science requirements prior to examination by their own boards. The Legislature has received testimony from official state sources showing that *no chiropractors whatsoever* have taken a basic science examination in Michigan for three (3) years, and only a handful of doctors of osteopathy have been examined. There are only a handful (5) of osteopathic schools in the United States, and the same situation applies regarding chiropractors. In fact, fewer chiropractors or osteopaths are being graduated each year throughout the country (the totals of both groups are dropping off annually).

STATES HAVE NOT been creating Basic Science Boards for a number of years, and during 1967 the State of Florida passed a law which will become effective in 1969 *repealing* its own basic science law. It is to be hoped that Michigan will, this year, follow Florida's example and remove a major roadblock to the recruiting of badly needed additional doctors of medicine to serve the people of Michigan.

MSMS to Continue to Oppose Senate Bill 227 To Liberalize State Chiropractic Practices

On January 2, 1968 a special communication was mailed to all members of MSMS pre-informing them that Senate Bill 227, which was vigorously opposed by the Michigan State Medical Society during the 1967 legislative session, would again be before the State House of Representatives during 1968.

This bill passed the State Senate over the Society's objections. If passed by the House, it would be presented to the Governor for signature or veto.

During 1967, the chiropractic bill nearly reached the stage of a vote by the House, but was finally returned to the House State Affairs Committee for further study, an action which MSMS applauded.

The bill had contained several objectionable features, chief among them being extremely vague language which would have authorized chiropractors to use, in the examination of patients, "other analytical instruments generally used in the practice of chiropractic."

Further, SB 227 would have stated that chiropractors would henceforth have the "right" to use X-ray in the examination of patients; no controls whatsoever were incorporated (for example, in licensing chiropractors for the first time two years ago in the State of New York that legislature expressly forbade chiropractors to X-ray patients below the age of 18 years and limited its use to certain areas of the body).

As was indicated in MSMS' January 2 letter to all members, the Chairman of the House State Affairs Committee has stated that *some form* of SB 227 *will* again be placed before the House. There has been indication that certain elements of the bill will be amended by the House Committee, however, before it is sent to the floor for debate and vote.

MSMS Position Firm

MSMS has maintained the position that the definition of what constitutes permissible chiropractic practice in Michigan at present should not be further liberalized. Indeed, Michigan's present chiropractic licensure law is more liberal in 10 separate major aspects than the type of law suggested for chiropractors in Quebec, Canada by Justice Gerard LeCroix after completion of a full year of exhaustive study of chiropractic throughout the world.

In coming weeks the Legal Affairs Committee will closely observe developments in connection with SB 227, working with the House State Affairs Committee as closely as possible to ascertain what amendments to the bill may be contemplated. These will be immediately reported to MSMS members with an analysis of their import.

SB 227 has been the subject of much debate by the House State Affairs Committee since the bill was returned to it in June of 1967. A two-day hearing was conducted in August; members of the committee have made several extended trips throughout the United States gathering background to enable them to make their decision as to recommending passage, rejection, amendments, etc. to this bill. Locations visited include Los Angeles, New Orleans, and Quebec, Canada. On several occasions MSMS has also had many legislators attend meetings at the Society Headquarters to discuss the implications of the bill.

Congress Rejects Chiropractic

Within the past 30 days the Congress of the United States rejected the inclusion of chiropractic services under Title 18, Medicare. Congress was urged to take this action by the National Council of Senior Citizens and others, and the Department of Health, Education and Welfare itself endorsed the proposal that it conduct a year-long, in depth study of chiropractic schools and practices throughout the United States before chiropractic services be further considered for recipients of Medicare.

Congress Study Underway

Such a study has been ordered and its results must be reported to Congress on January 1, 1969. MSMS maintains that the Michigan State Legislature would be well advised to follow the lead of the federal government and refrain from further expansion of an already liberal licensing law in Michigan pending the U.S. Government's study.

For a review of MSMS position on SB 227 as it was returned to the House State Affairs Committee in June, 1967, readers are referred to the editorial of MSMS President C. Allen Payne in the June, 1967 issue of *Michigan Medicine,* and also to the article appearing in the July, 1967 *Michigan Medicine* "News Extra."

Learn more about Legislative concerns at MSMS Conferences in Detroit, February 22-23-24. See Back Page for invitation.

Call Special Session Feb. 14 Of Delegates

A special session of the MSMS House of Delegates has been called for 1:30 p.m., Wednesday, February 14 at the Wayne County Medical Society Headquarters.

The only business that will be considered, reports Speaker James B. Blodgett, M.D., is "for the purpose of considering the report of the MSMS Treasurer and necessary implementation thereof."

The 1967 House of Delegates approved the recommendations of the MSMS Treasurer "in principle." The Council continued its study and heard a detailed proposal from Treasurer John R. Ylvisaker, M.D., at its December meeting and then requested that a special session of the House be called. The Council felt that a policy matter of this magnitude should be referred to the House and that a significant delay in the implementation of the recommendations would compromise the proposed program.

A five-page "Proposed Revision of MSMS Asset Management — A Program for Initiation and Implementation" from the Treasurer has been sent to the Delegates for their study.

Read, Save January Journal, Dedicated to WSU Centennial

The regular January issue of *Michigan Medicine* has been published in honor of the Centennial celebration of Wayne State University. The articles were contributed by members of the faculty and cover not only scientific material but also historical aspects of the growth of the University as well as educational programs, past, present and future.

It is interesting to note from the history of Wayne State University that the Medical School and its faculty played an important role from the very beginning. The growth of the Medical School over the past 100 years reflects the changes in administration first largely under specific individuals with private financial support followed by city and finally state control. With these changes there was tremendous growth not only in the size of the Medical School but also in its stature and recognition among sister universities.

The faculty of the Medical School and its alumni have made an enviable record. In increasing numbers they have become leaders on all levels of medical teaching, research and in their service to the care of the sick. With the construction of the new Medical Center in the middle of Detroit, there is little doubt that an even brighter future will be realized.

In the articles found in the January issue the names of many men who have contributed to the training of physicians and in research as a part of the family of Wayne State University are mentioned. Obviously, many more could have been included.

We salute Wayne State University on its 100th birthday and particularly its Medical School which has established a fine reputation not only in the State of Michigan but throughout the country. With the vigorous leadership that it now enjoys, we are convinced that it has a bright future in the fields of education, service and research.

George H. Lowrey, M.D.,
Scientific Editor

MEET THE LEADERS IN STATE LEGISLATURE:

The Michigan State Senate and House of Representatives, during the 1968 regular session, will be under the leadership of the Republican Party. The GOP maintains an extremely narrow majority — there are 19 Republican Senators and 18 Democratic Senators, and there are 56 Republican House members and 54 Democratic House members. The Party with the majority selects all committee chairmen and the presiding officers of both chambers.

Lieutenant Governor William Milliken presides over the Senate, and in his absence the presiding officer is Sen. Thomas Schweigert (R), Petoskey. Should Sen. Schweigert also be absent the job would fall to Sen. Gilbert Bursley (R), Ann Arbor. Majority Leader is Republican Senator Emil Lockwood (R) of St. Louis in Gratiot County, assisted by Majority Floor Leader Robert VanderLaan (R), Grand Rapids. Sen. Lockwood is also assisted by Sen. Charles Zollar, (R), Benton Harbor. Democratic Leaders in the Senate are Sen. Raymond Dzendzel of Detroit and Sen. Sander Levin of Oakland County, who has also recently been named Chairman of the Democratic State Central Committee.

In the House of Representatives, the Republican majority has elected Rep. Bob Waldron of Grosse Pointe as Speaker of the House, assisted in that office by Rep. Martin Buth (R), Grand Rapids or, in Mr. Buth's absence, by Rep. Roy Spencer (R) of Lapeer. The GOP majority floor leader is Rep. William Hampton of Birmingham, assisted by Rep. Charles Davis (R) of Onondaga in Ingham County. Republican caucus chairman is Rep. Arnell Engstrom of Traverse City, assisted by Rep. Russell Strange of Mt. Pleasant.

Democratic House members are led by Minority Leader Rep. William Ryan of Detroit, who has four assistant floor leaders: Rep. Bob Traxler of Bay City, Rep. Dan Cooper of Oak Park, Rep. Dale Kildee of Flint and Rep. Albert Kramer of Oak Park. The Democratic Caucus Chairman is Rep. Joe Snyder of St. Clair Shores, assisted by Rep. David Holmes of Detroit.

Three-Day Health Conference Set For Detroit, February 22-23-24

Every MSMS member is invited to participate in the "new three-day package" of health conferences February 22-23-24 in Detroit.

The program, which will focus attention on the leadership role of MSMS in the complex field of distribution of medical care, is being completed and soon will be mailed to every member.

Interested members, county society leaders, MSMS officers, councilors and committee workers are blocking out the days now. The calendar will read:

Thursday, February 22 – Conference on Legal and Public Affairs, New Center Motor Lodge, Detroit

Friday, February 23 – Conference on Medical-Hospital Affairs, New Center Motor Lodge, Detroit

Saturday, February 24 – Annual MSMS Component Society Leadership Conference, Wayne County Medical Society Headquarters.

OFFICERS OF MSMS have explained that the workshops will be of a "clearing house" nature to provide for an "exchange of information and viewpoints."

Following is the subject-matter breakdown for the new February non-scientific programs:

February 22 — Conference on Legal and Public Affairs

Morning: Malpractice
Privileged Communications
The Expert Witness

Afternoon: Revision of the Criminal Code
Revision of the Medical Practice Act
"Hot" Legislative Issues

February 23 — Conference on Medical-Hospital Affairs

Morning: Consideration of the Report by the President's Commission on Health Manpower
Voluntarism and the Michigan Health Council

Afternoon: Comprehensive Health Planning
Michigan Association for Regional Medical Programs

February 24 — Annual MSMS Component Society Leadership Conference

Morning: Report of the House of Delegates
Group Discussion re Ethics, Professional Conduct, Hospital Relations
Group Discussions re Legislation and Politics
Workshop for County Society Secretaries

Afternoon: Quackery and Public Education

Out-of-state experts and Michigan authorities in the various fields have been invited to the new MSMS programs.

THE THREE MEETINGS are scheduled consecutively to encourage members to attend more than one day. Many interested members, officers suggest, will want to attend the well-planned three-day package conference. Lodging arrangements have been made with the New Center Motor Lodge, on Grand Boulevard at Third, between the Henry Ford Hospital and the Fisher Building.

A number of MSMS committees will attend the programs in their area of concern and hold committee meetings to provide for follow-through on the information presented and the questions raised.

THE SCHEDULES for February 22 and 23 will include sessions in the morning and afternoon, with informal luncheons and cocktail receptions each afternoon. No formal banquets are planned; so the physicians and their wives will be able to enjoy the many entertainment and athletic events in the Detroit area if they wish.

The Saturday workshop, which in the past has been called the County Secretaries-Public Relations Workshop, or the MSMS Officers Conference, also will extend during the day, with no evening program.

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VIETNAM: THE OTHER WAR

See Page 248 for the Story of Michigan "Volunteer Physicians for Vietnam"

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 3
FEBRUARY, 1968

AMONG THE IMPORTANT ARTICLES:

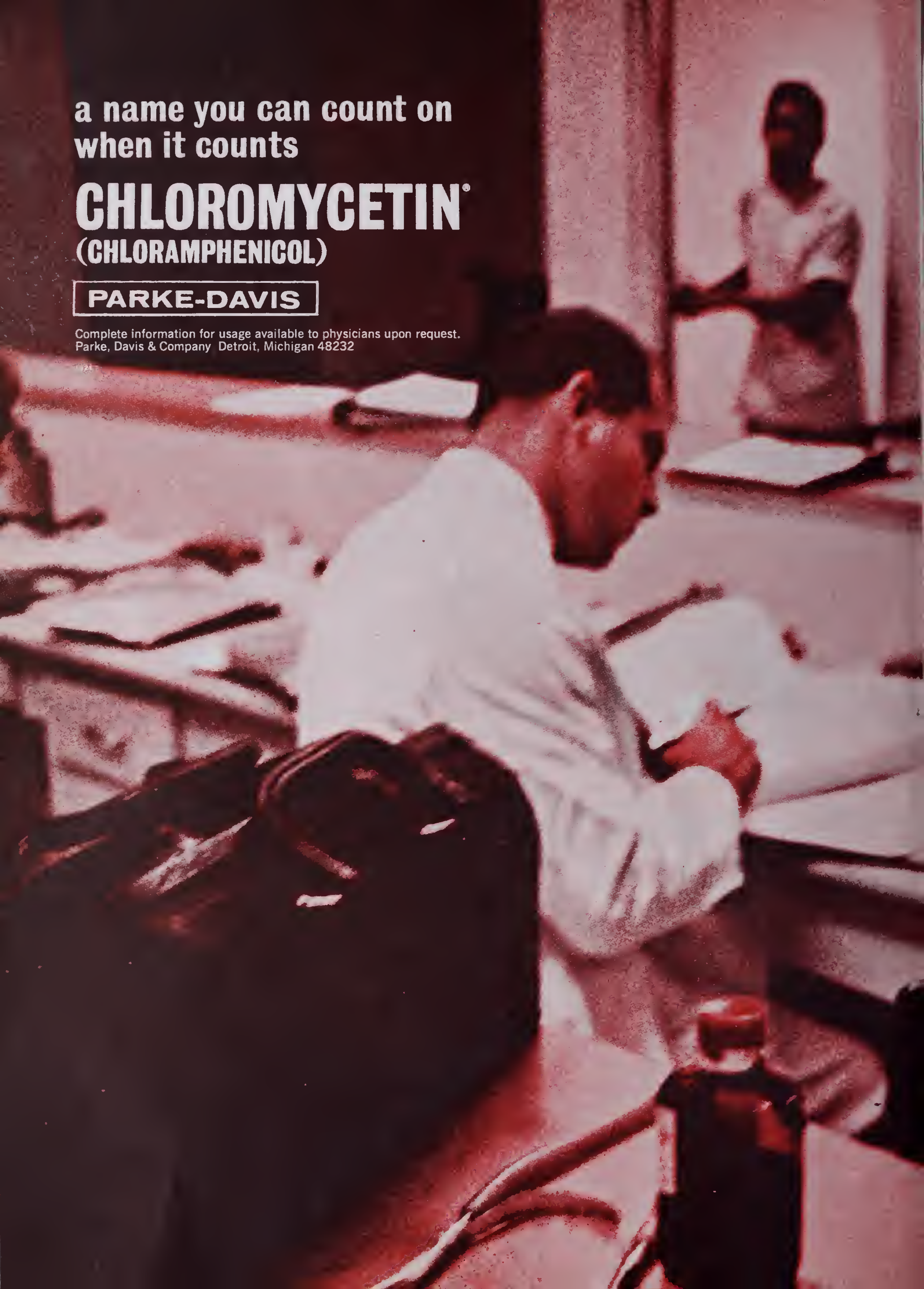
Lap Seat Belt Injuries:
The Treatment of the Fortunate Survivor

Where Does MSMS Stand re Legislation?

Reactions Wanted to Manpower Proposals

Four Targets Need More Health Education

SEE 227 — MSMS FEBRUARY CONFERENCES



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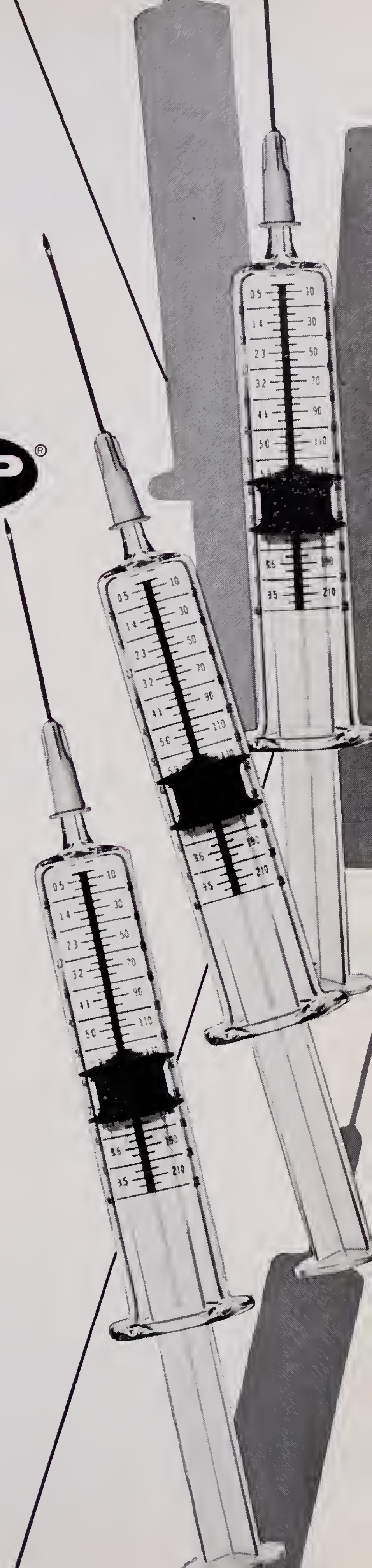

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ABOUT THE COVER

The cover calls attention to a feature article about Michigan doctors of medicine who have volunteered to serve in Vietnam. The photos were provided by the AMA Science News Department of doctors serving in the "AMA Volunteer Physicians for Vietnam Program" in the Mekong Delta region and with the Montagnards in the Central Highlands. See Page 248.

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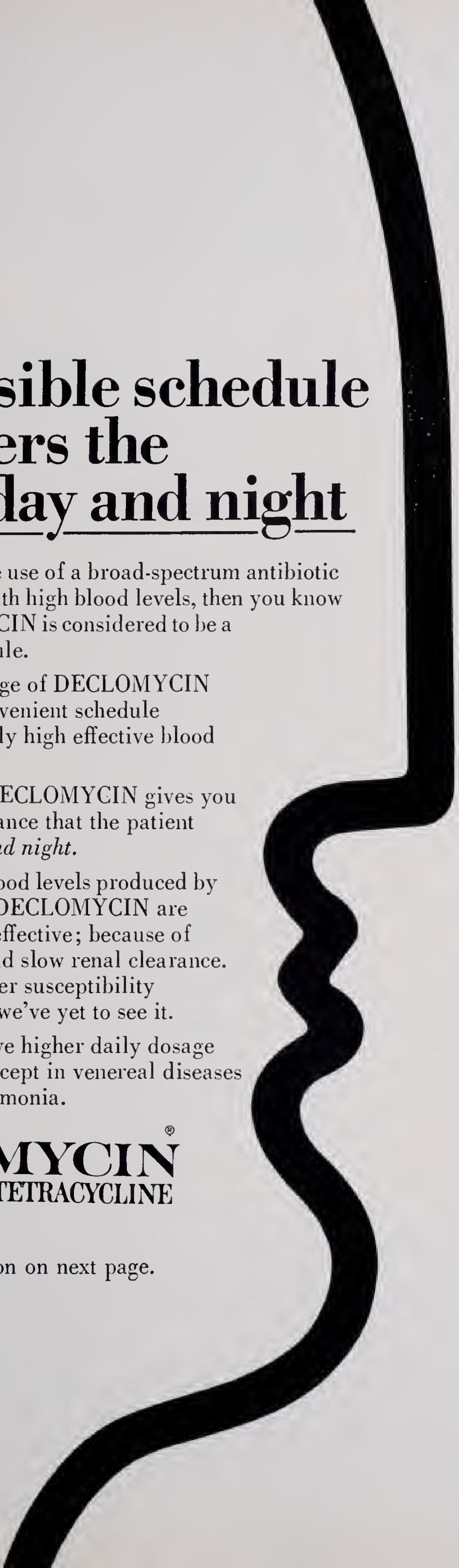

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DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Four Targets Need More Health Education

Individual doctors, county medical societies and MSMS need to work to increase and improve their efforts in health education to upgrade understanding of four critical community problems.

These four major concerns have been identified as targets by the AMA Department of Health Education.

THE FOUR AREAS—already the object of considerable MSMS effort—are listed as:

> "1. Sex education, or the broader concept of education for sexuality which includes interpersonal relations as well as sexual anatomy and physiology;
>
> "2. The control of syphilis and gonorrhea through case-finding and specific therapy;
>
> "3. Education for family living with emphasis on family health protection;
>
> "4. Education that may prevent or control habituation to such noxious or toxic substances as heroin, barbiturates, and other drugs, marihuana, tobacco, alcohol, and the volatile substances used in glue sniffing."

Health education in the community must be a major dedicated purpose and function of the county medical societies and its committees.

The county societies have a responsibility to their communities to cooperate and assist the schools, voluntary civic organizations, health-related associations, and the official agencies.

FIVE BASIC QUESTIONS can help serve as guidelines by the county societies and its leaders. The officers, chairmen and members must ask:

1. Who will do the job?
2. When will the job get done?
3. What problem needs solving?
4. Toward what target population is the educational effort to be directed?
5. What are others doing about the problem?

After these questions are carefully researched, then the county medical society should plan and develop a program of action.

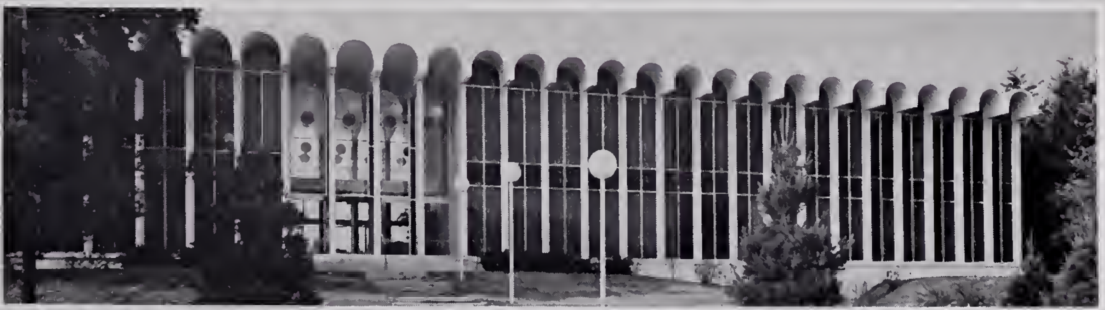
Health education is not easy. Evaluation must be continuous. The programs must be more than "noise." The measurement of success must be changes in attitudes and habits by the target population.

SUCCESSFUL ACTION programs usually incorporate many elements. Educational efforts usually involve MD efforts through schools and through community groups. Doctors have ready-made opportunities to serve as consultants for study units and for community service projects. The local news media should be brought into the team effort because they can conduct effective informational efforts and help change attitudes.

MSMS—AND THE AMA—are able and ready to help implement vital health education activities.

Physicians every day do carry out their responsibilities for health education in the privacy of their consultation rooms. This cannot be enough. Physicians both individually and collectively as medical societies have a responsibility to their community.

The opportunities are unique.



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Sustained circulatory, respiratory and cerebral stimulation for the

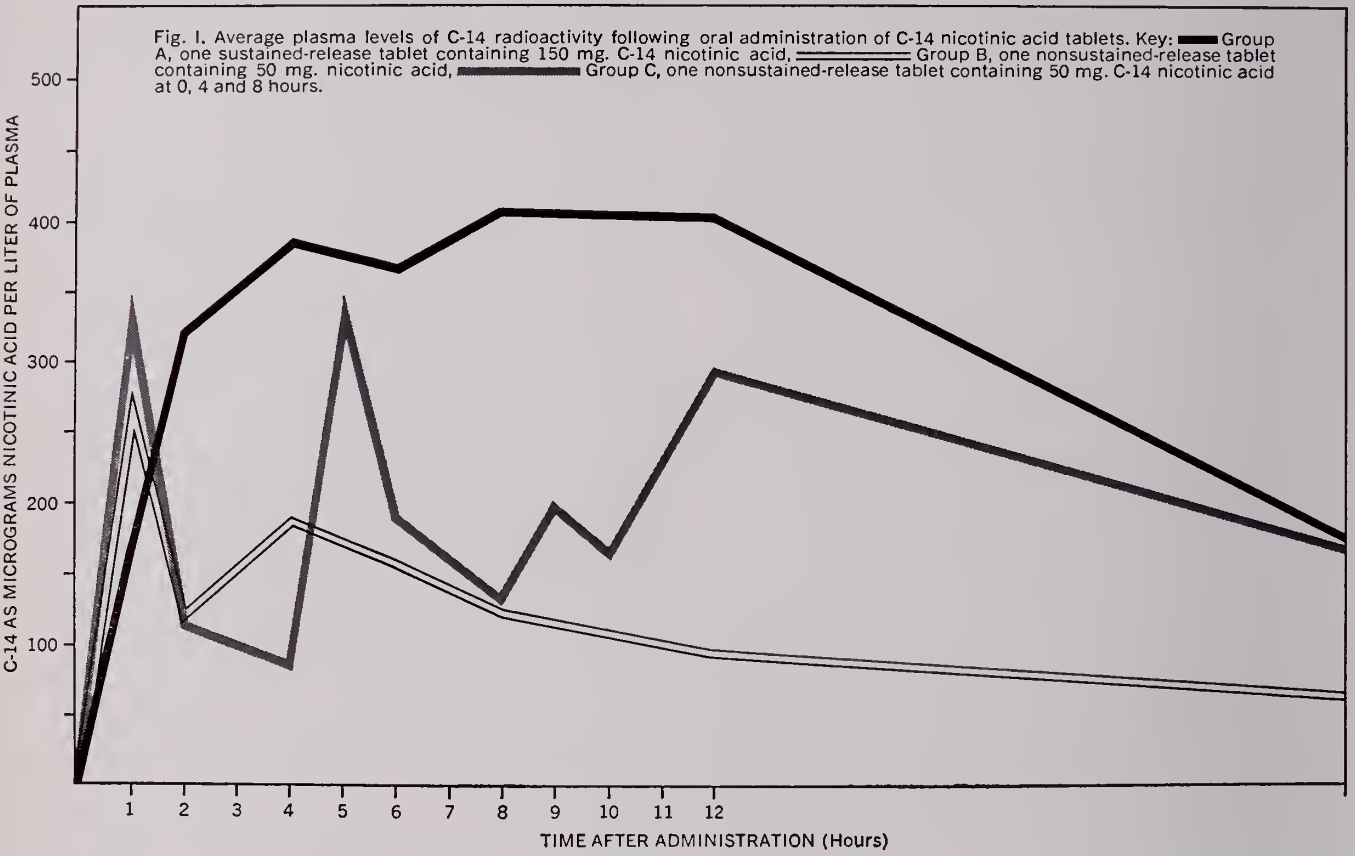

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

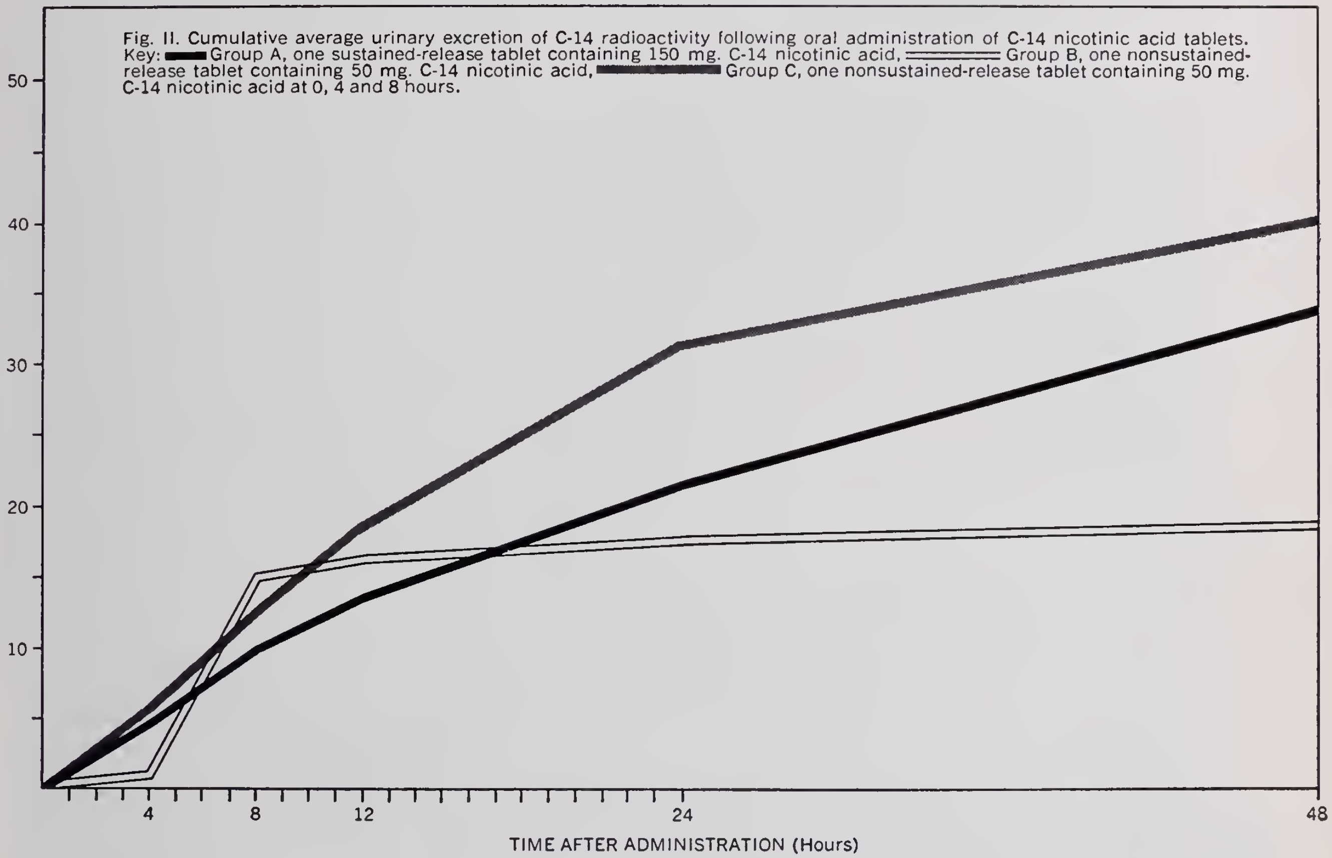
Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

C-14 AS MILLIGRAMS NICOTINIC ACID EXCRETED
50
40
30
20
10
4
8
12
24
48
TIME AFTER ADMINISTRATION (Hours)

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Lap Seat Belt Injuries; The Treatment of the Fortunate Survivor

BY RICHARD C. SCHNEIDER, M.D.
WILLIAM S. SMITH, M.D.
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ABSTRACT — The lap seat belt has prevented many traffic fatalities during the past decade. With the use of this protective device, however, certain characteristic traumatic lesions have occurred in some cases. A multidisciplined approach to their treatment and the possible prevention of such injuries by a combination of the cross-chest strap and lap seat belt is presented.

This multidisciplined clinical study is from the University of Michigan Highway Safety Research Institute. The study was supported by a grant made by Alvin M. Bentley and in part by USPHS grant UI-00008 from the Injury Control Program, National Center for Urban and Industrial Health.

Much of the initial data on occupant kinematics and injury reduction has been collected from simulated accidents employing dummies or cadavers as car occupants. At our institution on-the-scene investigations of fatal automobile accidents have been conducted, correlating the fatal injuries with the objects that produced these fatalities (ejection, steering, assembly, instrument panel, etc.)[15,16,18,19,20] and the pathologic findings in the fatally injured.

The present review was undertaken because there are few reports available which describe the special problems of persons wearing lap belts who survive accidents. A well-coordinated, multidisciplined team of physicians should provide not only treatment for the injured in such traffic accidents, but also assemble significant clinical data for research purposes as an aid to future injury preventative measures.

LAP SEAT BELTS have been proven effective in preventing many serious and fatal injuries.[1,2,3,11,12,13,23,27,42,45,46]

However, it is possible that a new protective device preventing one type of injury or fatality may cause undue stresses in other body areas producing different traumatic lesions. Sporadic reports have appeared in the literature related to seat belt injuries[5,6,8,9,10,14,17,22,24,26,32,33,37,41,44]; the most comprehensive review being presented by Snyder, et al.[38]

At the outset it must be emphasized that this article is written not to condemn lap seat belts but to advocate them, for without these safety measures more serious injuries and fa-

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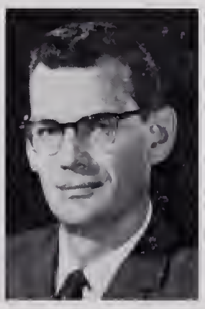
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talities would occur in automobile collisions. [20,46]

The substitution of a shoulder-lap belt combination[3,13,28,34,36] for only the single lap seat belt is gradually evolving as the next step forward which the public must take to afford further protection. Indeed, one may face the possible appearance of different important sequelae with this innovation, but like the use of lap seat belts, it should not be a deterrent from a shift toward improved safety equipment. Cooperative studies by the physician, automotive engineer, and highway safety teams must continue and be expanded.

FIVE CASE REPORTS of patients with injuries from automobile mishaps are presented to illustrate certain types of lesions which may be associated with the use of lap seat belts.

Because of the specific mechanisms involved, the investigation of these principles by the team approach provides a better understanding of the type of treatment which is necessary and the best opportunity for full recovery of that patient.

CASE REPORTS

Cervical Spine Fracture And Vocal Cord Paralysis

Case 1: [32*] R.M., a young millworker, was admitted to the hospital on June 5, 1962, having been injured 42 hours previously in a two-car collision. He was wearing a lap seat belt. Although stunned, he was not unconscious and recalled that his head had flexed acutely forward resulting in the steering wheel catching him beneath the chin (Fig. 1A). Immediately after the injury, his respirations were very labored with stridor and supraclavicular retraction. He could not speak above a whisper, and on attempting to swallow fluids a marked retropharyngeal swelling caused him to choke. There was a complete paralysis of the right vocal cord, marked paresis of the left cord, and displacement of the left arytenoid cartilage. Roentgenograms of the cervical spine demonstrated an avulsion of the neural arch of the second cervical vertebra from its body with slight disruption of the pedicles of the third cervical vertebra (Fig. 1B). A marked degree of swelling was demonstrated in the retroesophageal area at C4, C5, and C6 vertebrae.

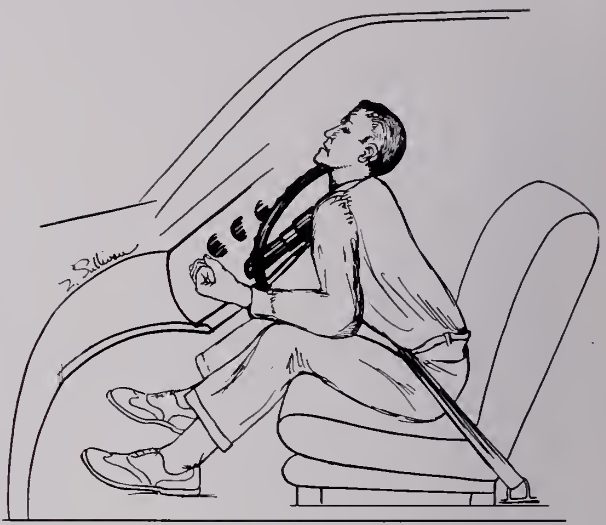

Fig. 1A:

Initially the patient sustains acute flexion of the cervical spine catching the chin on the steering wheel. The diagram demonstrates the severe hyperextension of the cervical spine, which, with the slumping of the body, provides the mechanism for the hangman's fracture.

Traction with Crutchfield skeletal tongs was applied shortly after admission to the hospital. A tracheostomy had been performed after the accident. With the exception of the above findings, there was no neurologic deficit. Skeletal traction was continued until shortly before discharge from the hospital nine weeks after injury, and a cervical brace was instituted (Fig. 1C). At this time the tracheostomy was still necessary. Subsequent laryngeal surgery was required to restore the patient's voice.

A follow-up evaluation on November 1, 1963, showed no neurologic abnormality except for slight soreness of the musculature of the neck.

Comment: The patient was originally admitted to the neurosurgical service because of his cervical spine fracture and was treated in skeletal traction as a method of stabilization. Because of his marked retropharyngeal swelling and the com-

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*Reprinted courtesy Journal of Neurosurgery, XXII, No. II, 141-154, (1965)

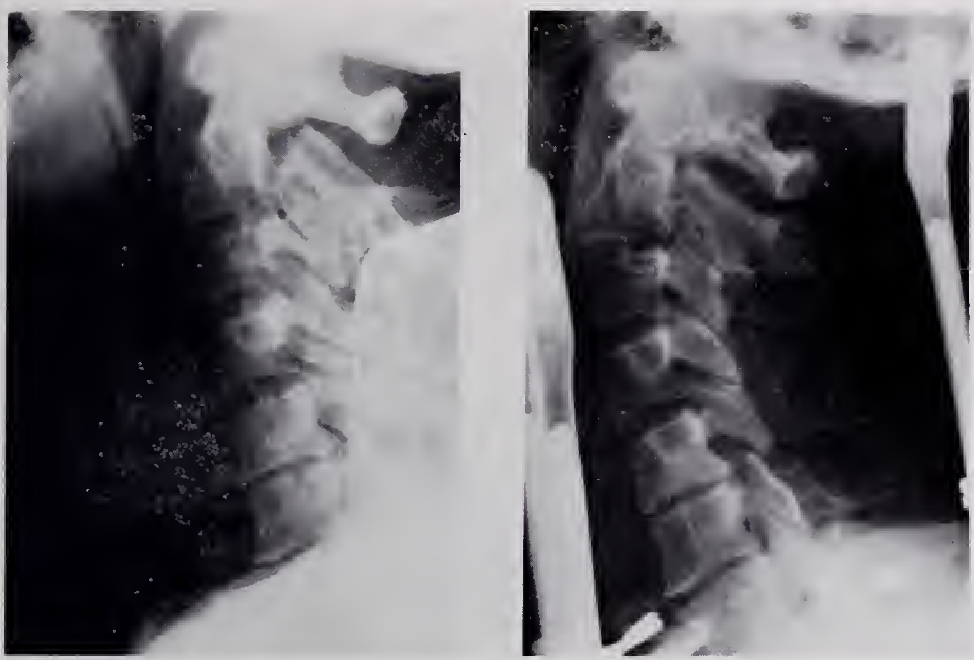


Fig. 1 (B & C).

Fig. 1B: Lateral x-rays show an avulsion of the neural arch of the 2nd cervical vertebra with slight disruption of the pedicles of the C3 vertebra. (From Schneider et al, Journal of Neurosurgery, 22, No. 2: 141-154, 1965).

Fig. 1C: Repeat cervical spine x-rays with the patient in a brace show good realignment and some healing of the fracture.

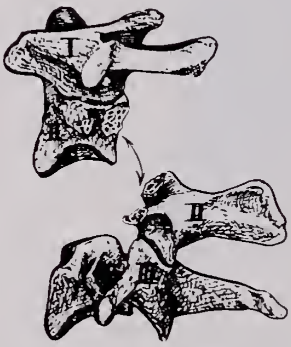
plete paralysis of his right vocal cord and paresis of the left one, it was necessary for him to have a tracheostomy. Subsequently, the otolaryngologist performed laryngeal surgery in order to restore the patient's voice.

The patient recalled flexing his forehead downward, catching his chin over the steering wheel and throwing his neck into some hyperextension. He was wearing a lap seat belt which, no doubt, prevented him from striking other parts of the interior of the car more severely but resulted in the patient "hanging" himself on the steering wheel.

In 1965, Schneider, *et al*[32] presented eight cases of traffic accidents in which the patients sustained a fracture-dislocation of C2 and C3 vertebra with a bilateral avulsion of the laminar arches from the C2 vertebral body. This injury usually was associated with little or no neurologic deficit, and the spine healed quite readily without operation as long as adequate external fixation was provided. A well fitting four-post brace worn for ten weeks is quite adequate for these purposes. This report was made by two neurosurgeons (Schneider and Livingston) working in cooperation with two British anatomists (Cave and Hamilton). The latter had observed that this highway accident injury was similar to that seen in judicial hanging where the "drop" technique was used. The lesion itself was ably described by Wood-Jones[47] (Fig. 1D) and subsequently confirmed by other authors.[43] The mechanism for the development of "hangman's fracture" is best related by quoting from the article by Schneider *et al*[32]: ". . . not only do the joints of the atlanto-axial complex confer upon the skull the requisite range of mobility (flexion, extension, rotation) but the complex itself serves also to transmit the weight of the cranium to the unmodified portion of the cervical spinal column, which begins at the third cervical vertebra.

The junction of the cervicocranium with the (so to speak) vertebral column proper constitutes a site of mechanical weakness in the spine and here the third cervical vertebra forms a fixed point. The application of such a disruptive force as that operative in judicial hanging will tend always to detach the cervicocranium from the rest of the vertebral column. The situation of the line of fracture in judicial hanging (through the neural arch of the axis or even through its body or through that of the third vertebra) is, therefore, understandable, particularly when the normal lines of transmission of cranial weight are appreciated (Fig. 1E). The weight of the skull and its contents is transmitted bilaterally through the occipital condyle, the lateral mass of the atlas, and the superior articular process of the axis, the two lines uniting in the body of the axis caudal to the base of the odontoid process. Thence, weight is transmitted farther caudally along three distinct lines, namely along the line of the vertebral bodies and discs medianly and along the line of the pre- and post-zygapophyses bilaterally. These three lines of transmission diverge from the focal point in the body of the axis already mentioned, each of the lateral lines passing through the weakest point of the neural arch of the axis which is thus predisposed to rupture in a hangman's fracture, however induced. Naturally, the sequelae of hangman's fracture can be studied only in victims of traffic accidents who have sustained such a fracture and yet have survived."

Fig. 2.



The lesion present in Captain C. F. Fraser's series of judicial hangings. Separation of the arch of the axis from the body; effect of a submental knot.

Fig. 1D:
Reprinted from article by F. Wood-Jones[47]

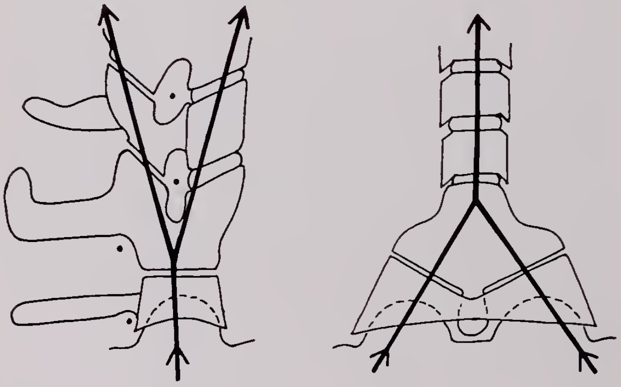


Fig. 1E:
Anterior and lateral aspects of craniocervical region to illustrate the lines of transmission of cranial weight through the atlanto-axial complex to the spinal column proper and the consequent mechanical vulnerability of the neural arch of the axis (A.J.E. Cave). (From Schneider et al, Journal of Neurosurgery, 22, No. 2: 141-154, 1965)

Perhaps some of these neck fracture patients sustain their injuries on the steering wheel or, in a similar fashion, by "hanging" themselves on the instrument panel with severe hyperextension of the cervical spine and the downward jerk of the body as it flexes forward to the floor of the vehicle.

Lumbar Spine Fracture-Dislocation And Perforation of Small Bowel

Case 2: This nine-year old, right handed girl, was involved in an automobile accident on March 4, 1966. She was thrown forward striking her head against the right side of the instrument panel rendering her transiently unconscious. This occurred in spite of the fact that she was wearing a lap seat belt. It should be emphasized that the seat belt was somewhat loosely applied. She had a headache and lower back pain. Her vital signs were normal and her pupils were equal and active. There was bilateral periorbital ecchymosis which was more marked around the left eye. She had bilateral abrasions and ecchymosis over the iliac crest and the inguinal ligaments (Fig. 2A). With the exception of the marked spasms of the abdominal musculature, originally attributed to spinal cord injury and abdominal wall contusion, there were no neurologic findings.

X-rays of the skull demonstrated a linear left frontal skull fracture (Fig. 2B). The lumbar spine films demonstrated a distraction fracture-dislocation at the L2-L3 intervertebral space with a mild compression fracture of the L3 vertebral body (Figs. 2C and 2D).

The patient was treated initially with bed rest only. Her abdominal signs disappeared and she began eating normally. Thirteen days following her injury the surgical intern noted increasing right lower quadrant tenderness. Subsequently, she became nauseated and vomited intermittently. The WBC rose to 13,500 and a flat plate and upright x-ray of the abdomen were compatible with bowel obstruction. General surgical consultation was obtained and operation was advised. At operation a point of nearly complete obstruction of the distal ileum 10 inches proximal to the ileocecal valve was found. The ilium had been injured on its mesenteric border in two adjacent areas. The obstruction was caused by a combination of scarring and adhesions of nearby loops of bowel to the site of injury. Ten inches of small bowel were resected (Turcotte) and continuity was re-established by an end-to-end anastomosis. Two-hundred ml of sterile serous fluid was aspirated from the peritoneum. Pathologic examination of

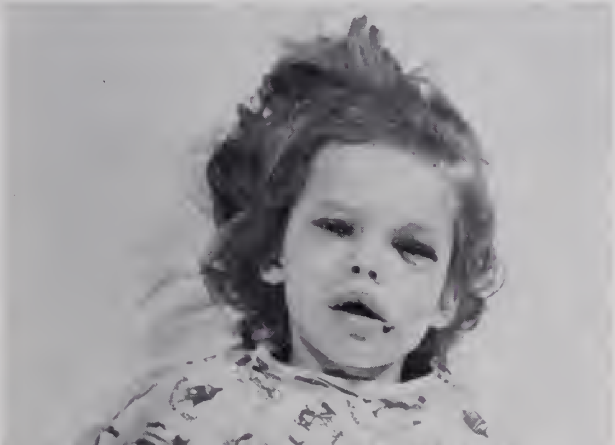


Fig. 2A.
The photograph taken a week after injury shows bilateral periorbital ecchymosis, a laceration at the left angle of the mouth, and bilateral abdominal abrasions above both iliac crests in the inguinal regions anteriorly.

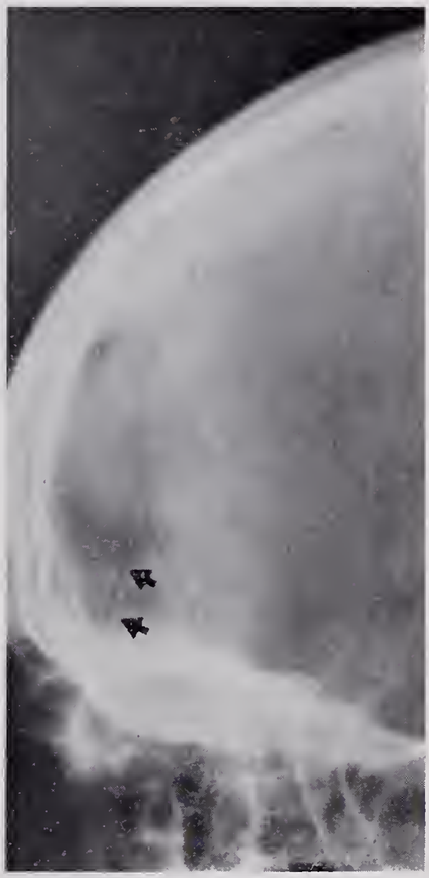


Fig. 2B.
The skull x-ray demonstrates the left linear frontal fracture.

the resected bowel demonstrated a probable site of perforation which subsequently sealed. On April 5, 1966, the orthopedic surgeon (Smith) exposed the spinal distraction fracture-dislocation site and found rupture of the interspinous ligament, rupture of the capsular ligament of the facets, rupture of the ligamentum flavum and complete dislocation of the facets. The L2-L3 interspinous distance was approximately twice normal. These spinous processes were wired together and a spinal fusion was performed using an iliac bone graft. Post-operative x-rays of the lumbar spine showed almost complete correction of the deformity (Figs. 2E and 2F). She was placed in a body cast and discharged from the hospital on April 21, 1966. At this time she was neurologically negative and asymptomatic.

Comment: This little patient had a combination of cranial, spinal, and abdominal injuries, possibly due to the fact that her seat belt was not properly tightened.[1,27] Nevertheless, this restraint very likely kept her from striking her chest and abdomen against the instrument panel, the object most frequently struck in front right passenger fatalities.

Fortunately, the skull fracture was merely a linear one in the frontal area. It was uncomplicated by any intracranial traumatic lesion. Smith and Kaufer[37] have shown that while a myriad of lesions is produced in belted individuals the only lesion that is unique to seat belt (lap) users is the pattern of the mid-lumbar spine injuries. Unlike any other lumbar spine injury it is characterized by:

1) Rupture of the interspinous ligaments, consequently widening of the interspinous space.

2) Rupture of the capsular ligaments of the facets.

3) Complete rupture of the ligamentum flavum.

4) Marked widening of the intervertebral foramina.

5) Minimal compression of the anterior-most part of the lower vertebral body, or a variation of the pattern, the chief of which is a fracture extending horizontally through the body, the pedicle, the transverse process and the spinous processes.

This pattern has been duplicated twenty-one times in this series. The lap seat belt modifies

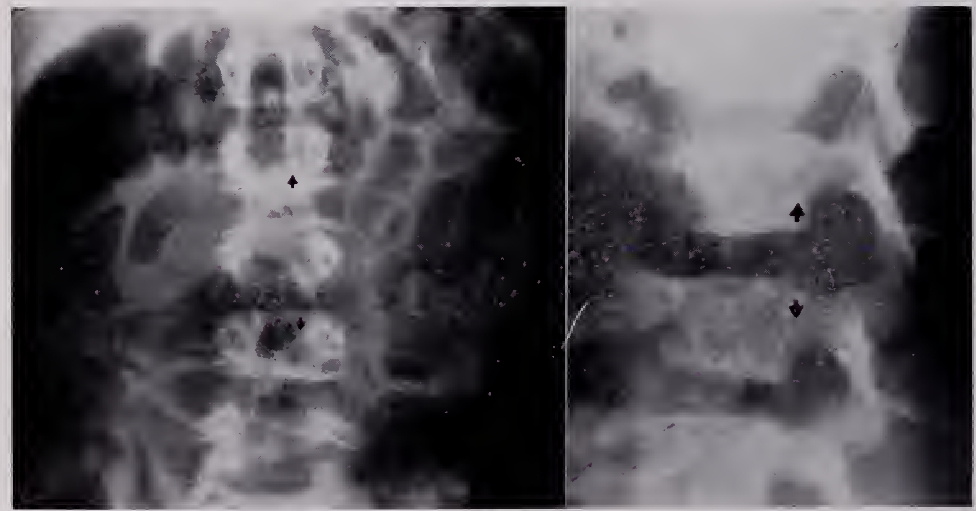


Fig. 2 (C & D).

Fig. 2C. Lumbar spine x-rays demonstrate the degree of distraction at L2-L3 and L3-L4 intervertebral spaces. This is well illustrated by the arrows adjacent to the distorted spinous processes.

Fig. 2D. The lateral view of the lumbar spine demonstrates the enlargement of the L2-L3 intervertebral foramen due to distraction of the joints.

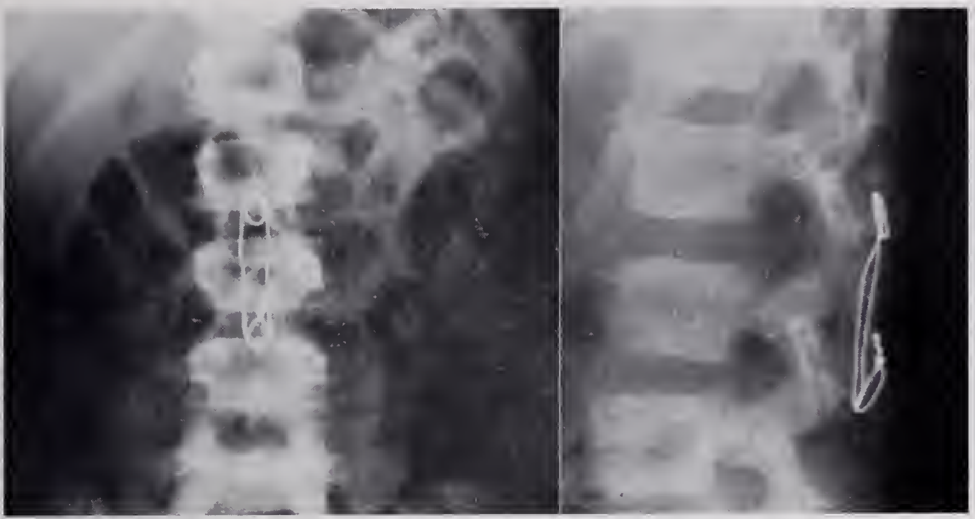


Fig. 2 (E & F).
These x-rays show the reapproximation of the L2 and L3 spinous processes and the stabilization of the lumbar spine by the wiring and spinal fusion which was performed.

the collision forces in such a way as to be a significant factor in the production of this unique lumbar spine injury.

Neither the skull fracture nor the distraction-fracture of the spine was associated with neurologic deficit. The abraded skin across the groin bilaterally is a typical lap seat belt contusion.[9] The child's initial abdominal signs were probably due to a combination of contused abdominal wall and a contused or perforated bowel. Although spinal cord injuries may be associated with a paralytic ileus, a fracture-dislocation at the L2-L3 interspace could not account for the rectus muscle spasm. A spinal cord injury at this level would manifest itself by neurologic signs in the lower extremities, and not in the trunk or abdomen. The signs which appeared two weeks after injury were due to intestinal obstruction. Alertness of the surgical intern in detecting these signs and the prompt surgical treatment allowed complete recovery from this injury. Surgeons should be aware that injuries severe enough to contuse the abdominal wall may also contuse intra-abdominal viscera. This may lead to delayed perforation, scarring, hemorrhage, or intramural hematoma formation in bowel. Other cases of lap seat belt injuries associated with ruptured viscera have been been reported.[5,9,22,41]

A comprehensive review of the various seat belt injuries has been presented by Snyder *et al.*[38]

Fractures of Roofs of Both Orbits And the Naso-orbital Region

Case 3: I.S., a small forty-one year old, right handed housewife, was occupying the front passenger seat in an automobile which was involved in a head-on collision on December 14, 1966 (Fig. 3A). The resulting damage was photographed by the anatomist (Huelke). The patient's husband, who did not have his seat belt fastened, struck the windshield (Fig. 3B) and sustained lacerations and bruises of his face and scalp. He was not rendered unconscious. His wife had her lap seat belt fastened but nevertheless struck her head on the edge of the instrument panel (Figs. 3C thru 3F). She did not lose consciousness. Upon examination her blood pressure was 170/100 and her pulse was 88 per minute. There was a bloody serous fluid exuding from both nostrils. She had a 4-centimeter laceration medial to the right eye, but her

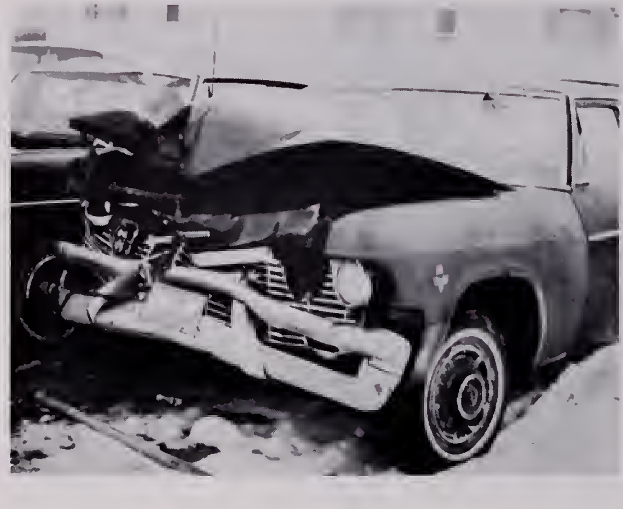


Fig. 3A.

The result of the head-on collision in which the patient was injured is shown.

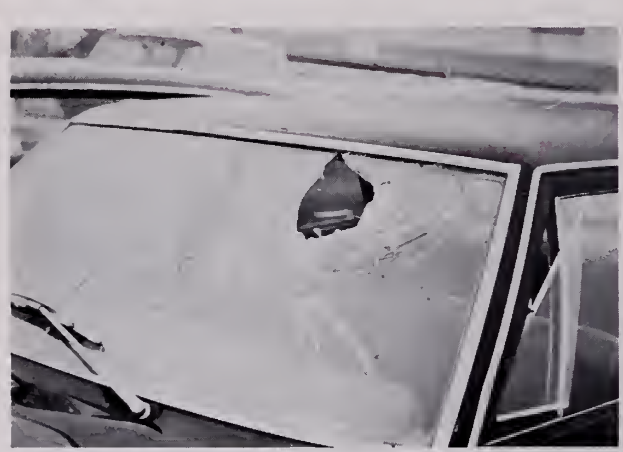


Fig. 3B.

The driver, who was not wearing a seat belt, struck the windshield with his head. The point of impact is at the center of the 'spider web' of shattered glass, while the point where he sustained his lacerations is about six inches below. This downward arcing of the head thus accounts for the slicing lacerations so commonly seen in accident victims striking the old type of windshield glass.[21] (Since 1966 American model cars have used a new improved windshield which markedly reduces the frequency and severity of facial lacerations).

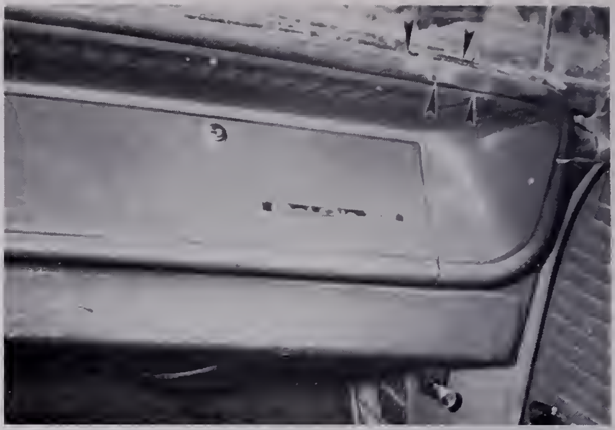


Fig 3C.

The patient, riding in the guest passenger seat and wearing a seat belt, was thrown forward so that his head struck the unpadded and unyielding instrument panel. Only smudge marks on the edge of the instrument panel indicated the point of impact.

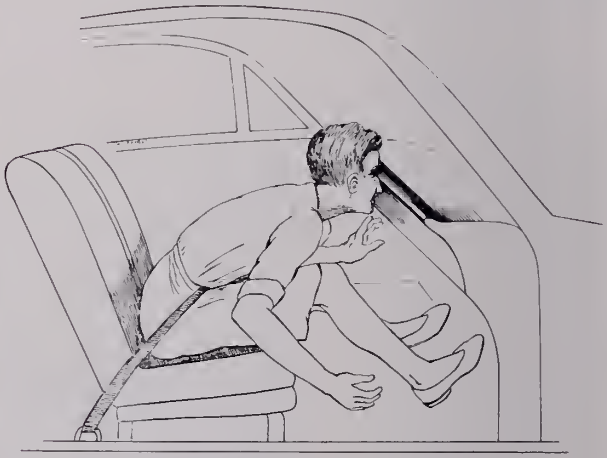


Fig. 3D.

The acute symmetrical blow of the head against the dashboard is shown with considerable hyperextension of the neck. Note the restraining action of the seat belt with the associated flexion of the lumbar spine. This type of pattern is especially true for small occupants. Taller individuals will strike the top of the instrument panel.

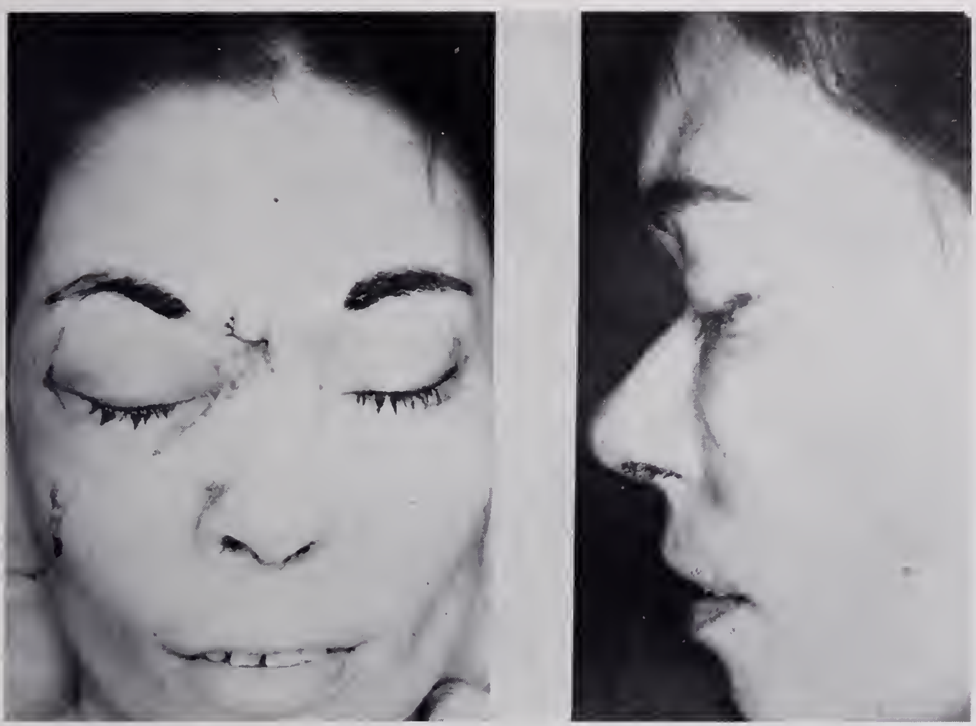


Fig. 3 (E & F).

The anterior and lateral view exhibit the compound fracture of the nose and marked inward displacement of the nasal bone.

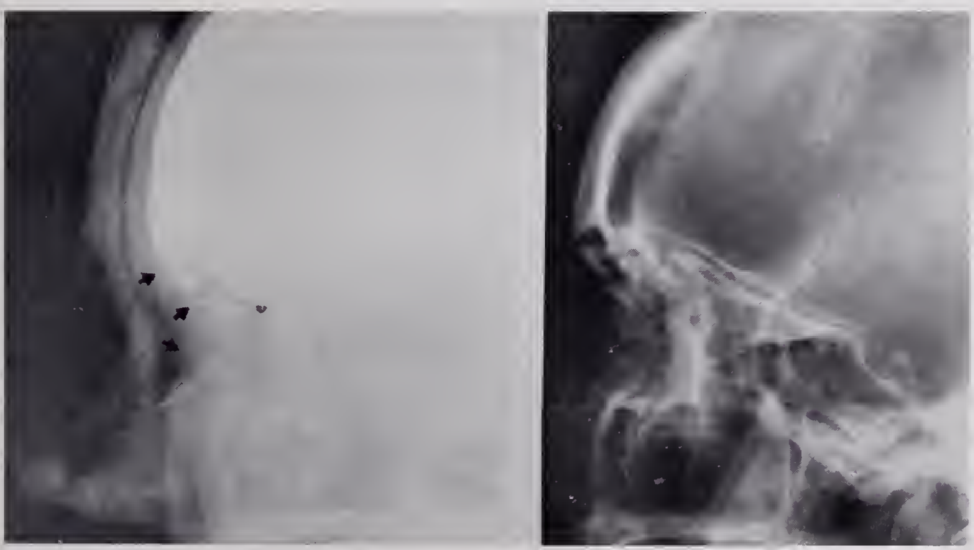


Fig. 3 (G & H).

Fig. 3G: The lateral view of the nose shows the comminuted depression of the nasal bone. The paper-thin bones (lacrimal bone and lamina papyracea of ethmoid bone) which make up the medial wall of the orbit have also been fractured and displaced backward.

Fig. 3H: The fracture of the cribriform plate is demonstrated anteriorly.

pupils were equal and reacted to light. A subconjunctival hemorrhage was noted in the right eye and the extraocular movements impaired in all directions; the right pupil was 2 millimeters larger than the left. The remainder of her neurologic examination was normal.

Skull x-rays showed pneumocephalus and demonstrated the depressed comminuted compound fracture at the nasion (Fig. 3G) with fractures of the roof of both orbits as well as fractures of the right zygoma, nasal bones, and medial walls of both orbits (Fig. 3H).

A transcoronal incision was made and a bifrontal craniotomy based on a right temporal muscle flap was performed by the neurosurgeon (Schneider). The inner table of the frontal region had been avulsed from the outer table bilaterally as a solid piece (en bloc) carrying with it

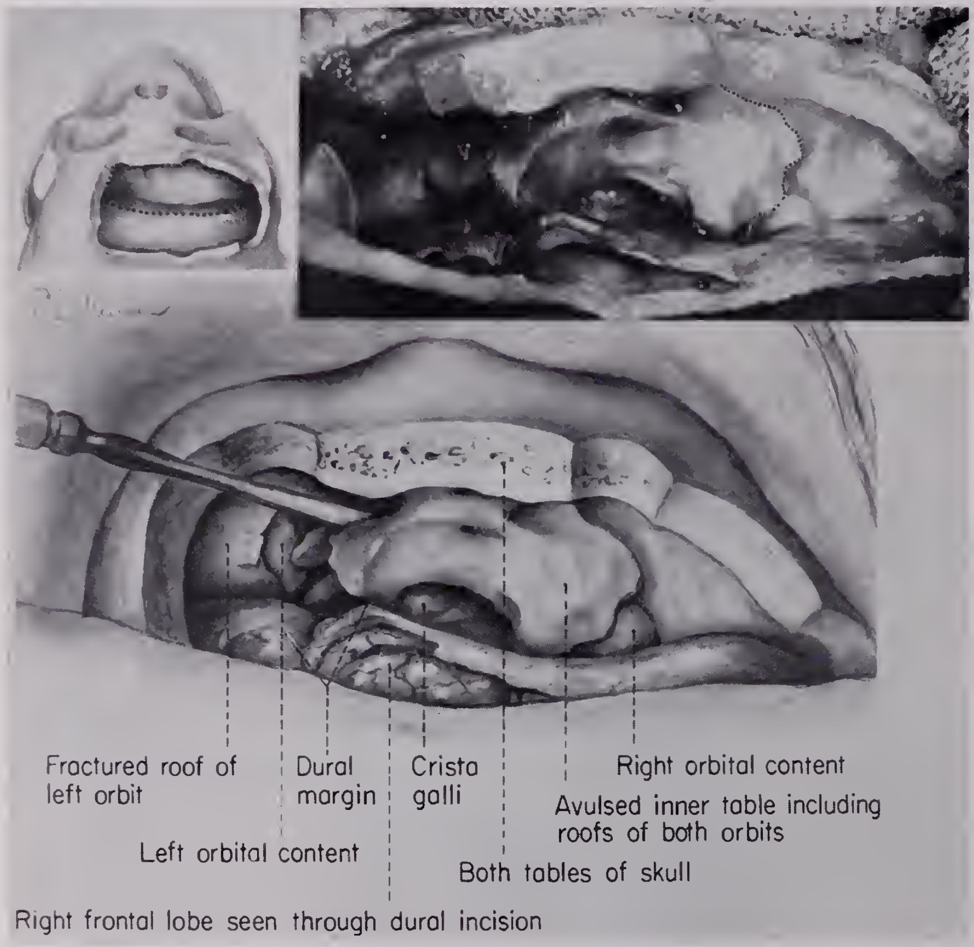

Fractured roof of left orbit
Dural margin
Crista galli
Right orbital content
Avulsed inner table including roofs of both orbits
Left orbital content
Both tables of skull
Right frontal lobe seen through dural incision

Fig. 3I.

Insert top, left: Site of craniotomy exposure.

Insert top, right: Actual photograph of site of "en bloc" avulsion of inner table of frontal bone bilaterally including cribriform plate, crista galli and the roof of both orbits (dotted line).

Lower diagram: This drawing identifies the structures at the site of the lesion seen in the photograph above.

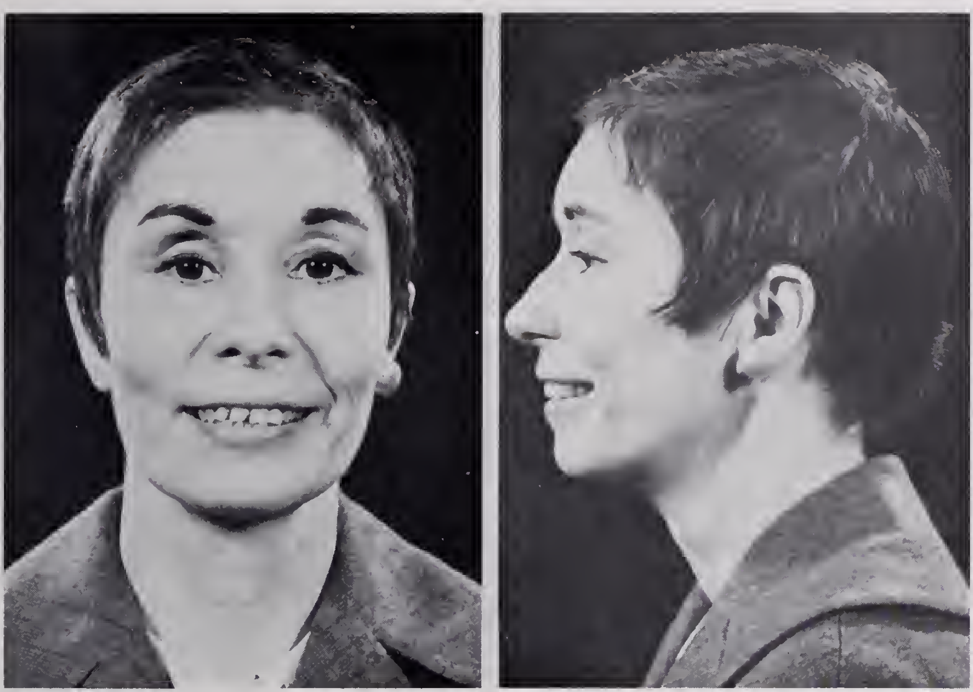


Fig. 3 (J & K)
The patient is seen five months postoperatively with the nasal bones in their normal position.

the crista galli and the anterior portions of the roofs of the orbit bilaterally (Fig. 3I). The inner and outer bone tables were wired together. The posterior orbital roof was completely morcellated bilaterally and had to be excised piecemeal. Four lacerations in the dura could be readily closed by simple suture. When these suture lines were tested by the injection of indigo carmine intradurally, the dura was watertight. The plastic surgeon (Grabb) then repaired the facial lacerations and performed an open reduction and internal wire fixation of the nasal fractures. The patient received triple antibiotic therapy and made an uneventful recovery. She was discharged on December 30, 1966, with slight diplopia on left lateral gaze.

Five months postoperatively at a return visit she was mentally alert, asymptomatic, and had obtained a good cosmetic result (Figs. 3J and 3K).

Comment: In this accident the driver was not wearing his lap seat belt and was thrown forward over the steering wheel striking the windshield with his face. The lacerations which he sustained were typical of those occurring by downward head movement with the face passing through the glass as has been described by Huelke, Grabb, and Dingman.[21] The point of impact in this accident was head-on, more in line with the front guest passenger; the driver was somewhat protected by the steering wheel.

In the case of his wife, who was in line with the impact, the seat belt undoubtedly saved her life but nevertheless she struck her head on the unpadded and unyielding instrument panel. Externally the most striking feature of her injury was a markedly depressed naso-orbital fracture, the extent of which was confirmed by the x-ray examination. She also had bilateral bloody cerebrospinal fluid rhinorrhea indicating communication with the subarachnoid space. If such drainage is permitted to continue untreated surgically, the result may well be future chronic bouts of meningitis, or brain abscess and subsequent death.[31]

In this case the skull fracture was unique in that the entire inner table of the skull, including the crista galli and the roof of both orbits was avulsed completely and almost symmetrically, en bloc, as a single huge fragment of bone.

Although there were multiple bony fragments at the posterior portion of the orbits, fortunately there was no damage to the orbital contents. This has not been the usual experience of the neurosurgeon who has repaired approximately 75 such post-traumatic frontal cerebrospinal fluid fistulae. The orbit is often injured, the optic nerve may be avulsed, and usually the cribriform plate buckles in such fractures with several bony spicules lacerating the dura and occasionally penetrating and becoming imbedded in the brain.[30] Such dural lacerations are frequently associated with large dural defects and usually require a dural graft. In the case here reported there were only four linear dural lacerations without any loss of this tissue so watertight closure could be obtained by simple interrupted black silk sutures. The lack of avulsion of the dura can be accounted for by the massive single bony fracture. Such an en bloc fracture of the skull probably requires a direct symmetrically applied blow to the base of the nose. This case supports two old neurosurgical adages:

1. There is always 100 per cent more damage to the skull visualized intracranially at operation than is seen in the preoperative skull x-ray of the patient with this type of fracture.
2. Some of the worst skull fractures often are associated with little or no brain damage, for there is a dissipation of force instead of the direct force transmission to the brain.

Dingman, *et al*[7] have urged the early reduction and fixation of this type of nasal fracture to prevent chronic facial deformity or disfiguration. The excellent cosmetic result attained in this patient supports this dictum and demands that it receive further active support.

Facial Laceration And Back Strain

Prevention of severe facial and intracranial injuries from head impact can be accomplished by adequate instrument panel design in the head impact areas. This is illustrated in the following case:

Case 4: Two women, both short of stature, were driving with the front seat moved well forward. Both were wearing the lap seat belts. The car was forced off the road; it struck a tree at 20-25 m.p.h. The impact was to the center front of the car. The passenger flexed over her belt and struck the unpadded instrument panel with her face (Fig. 4). Besides bilateral periorbital ecchymosis, she had a hairline fracture of her left maxilla. An "L" shaped laceration between her eyebrows was sustained when she struck the corner of the radio grille which did not deform with the instrument panel. Her main complaint was a sore back. She had stretched the vertical deep back muscle group from the coccyx to the upper lumbar area. At the time of the accident her seat belt was worn high,

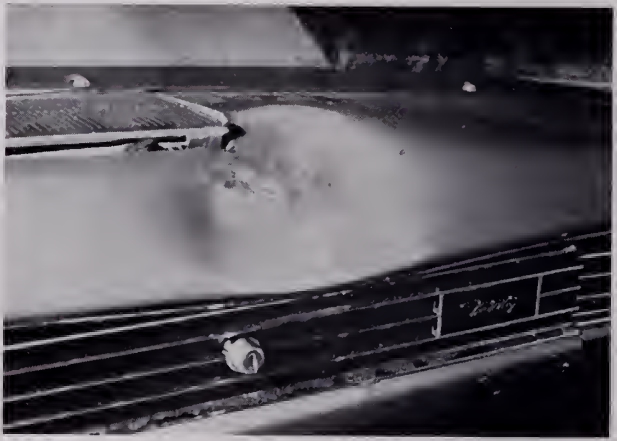


Fig. 4

Facial impact of a seat belted passenger onto an unpadded instrument panel. The occupant sustained a hairline fracture of the left maxilla, an "L" shaped laceration between the eyebrows from the edge of the radio grille. Stretching of the deep back muscles in the lumbar area was the main complaint of the patient.

above the iliac crests, and she had on a "substantial" foundation garment. Several weeks later her back problem resolved itself without clinical treatment.

Comment: In this case the instrument panel deformed, dissipating the impact energy. It is this type of instrument panel response to head impact that is required for the seat belted occupant. Padding over this deformable metal panel would have spread the impact load over a wider area and possibly prevented most of her facial injuries. The seat belt not being worn properly and the possible restraining effect of her foundation garment prevented adequate flexion over the belt, causing severe strain of the deep back muscles.

Brachial Plexus Involvement

Case 5: A young driver, who had lost his license due to numerous driving violations, lost control of the car on a curve, crossed the center line, and struck another car. Both vehicles struck right front to right front. The driver at fault was not wearing a seat belt. He struck his head on the right side of the instrument panel and died of intracranial injuries.

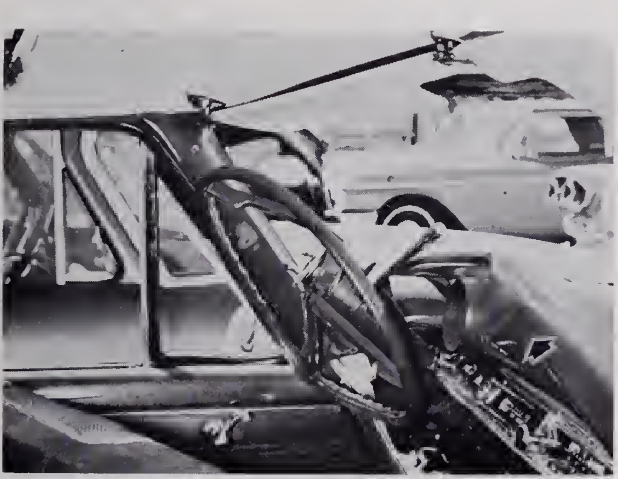


Fig. 5

Collapse of the steering wheel by a seat belted 230 pound male driver. Minor facial lacerations and a sore chest were sustained from wheel impact. His right shoulder struck the instrument panel producing a stretching of the brachial plexus roots and partial loss of shoulder joint function for six months.

The sixty-two year old 230 pound male driver of the other car was wearing a lap seat belt. He flexed over the seat belt and collapsed the steering wheel sustaining a sore chest and facial lacerations (Fig. 5). His right shoulder had struck the instrument panel and he had suffered marked paresis of the right deltoid, supraspinatus and infraspinatus muscles with slight weakness of the right triceps and biceps muscles and a minimal hypesthesia over the C4 dermatome. There were compression fractures of the T9 and T10 vertebrae with paravertebral hemorrhage, a fracture of the right acetabulum, the right inferior ramus of the pelvis, a fracture of the radial head of the right elbow, a trimalleolar fracture of the right ankle, fractures of the left zygoma and the right maxillary sinus.

The patient was in traumatic shock at the time of admission to the hospital. After this had been treated a general surgeon sutured the facial lacerations including a transected parotid duct. The trimalleolar fracture was reduced and stabilized by internal fixation and the fracture of the right elbow placed in a cast by the orthopedic surgeon. The neurosurgical consultant reviewed the symptoms referable to the right upper extremity and made a diagnosis of brachial plexus stretch injury which was treated by support and physiotherapy. The patient's course was one of continued improvement with discharge from the hospital six weeks after the injury.

Comment: In this severe accident the unbelted driver of the one car moved out of his position behind the wheel to sustain fatal injuries when he struck his head on the right side of the instrument panel. On the other hand the belted elderly driver of the second vehicle survived although he had multiple injuries which were rather successfully treated by a team of surgeons. In this case the lap seat belt no doubt saved the patient's life.

DISCUSSION

The multidisciplined approach to the care of highway injuries not only provides a better treatment for the patient but reveals some interesting lesions possibly related to the use of lap seat belts: the hangman's fracture (Case 1), the distraction fracture of the lumbar spine (Case 2), injury to the abdominal viscera (Case 2), and the "en bloc" fracture of the inner table of the skull and naso-orbital region (Case 3).

DeHaven, *et al*[6] have pointed out that injuries which seem directly related to the lap seat belt "are actually determined by other factors such as a failure of safety belt installations and vertical acting crash forces." Garrett and Braunstein[14] studied the "seat belt syndrome" in 3,637 occupants of 2,778 accident-involved automobiles and found 150 of these people had received an injury to the lower torso. Of these, twenty-six injuries were regarded as serious, consisting of intra-abdominal injuries (7), pelvic fractures (7), and lumbar spine fractures (12); but the majority of these people were in very severe accidents. These authors were able to find only a single case of a fatal lower torso injury in this group, thus demonstrating the effectiveness of the lap seat belts. Greater lap belt snugness by inertia reels[28] might have afforded increased protection in Case 2.

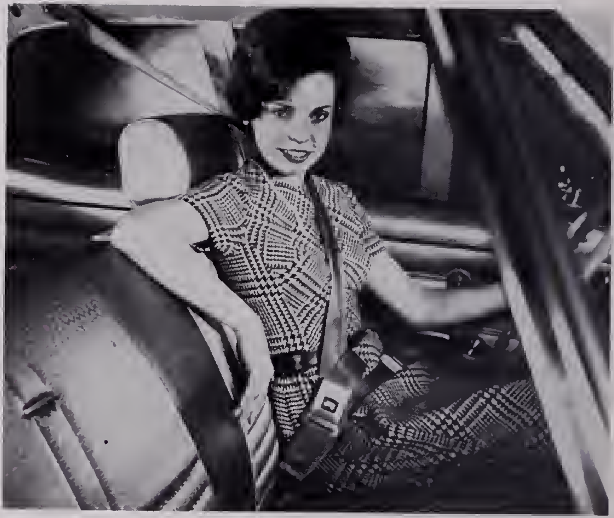


Fig. 6

Lap-shoulder belt combination. Note individual buckles for the lap and for the shoulder belts.

THE LIMITATIONS OF seat belts have also been recognized.[25] The single upper torso restraint is highly undesirable, for without an accompanying lap seat belt the passenger slides out underneath such a harness (submarines) and is liable to added injury such as fractures or dislocations of the cervical or thoracic spine.[12,15] When the three point system is used in which the diagonal strap is joined to the lap belt, there is a tendency for the lap belt to be pulled upwards onto the soft abdominal wall. It has been recommended that the lap and shoulder belt be separate (Fig. 6), for this combination does not have the undesirable characteristics of the other systems mentioned above. Such a double, independent belt system will still offer lap belt protection for those who for some reason will not wear the shoulder belt. A lap-shoulder belt combination (Fig. 6) would very likely have offered sufficient upper torso restraint in all cases so that it is doubtful whether the chin would have been caught upon the steering wheel (Case 1) or the head impacted against the dashboard as occurred in the other cases. The importance of available "cabin space" has been emphasized by Huelke and Gikas; for when there is collapse and compromise of the cabin area, the value of any restraint system is negated.[20] There is a definite need for an adequate child restraint system.

It is possible that restraining the pelvis and upper torso by the use of the lap and shoulder belts may occasionally permit the cervical spine to be snapped at the time of forward impact in rear end collisions. Hyperextension of the cervical spine can be prevented by the use of a head support. It is possible that if such a head restraint is not adequately designed, the head and neck could sustain a severe blow as they swing back and strike the head support. Since there is a certain degree of inertia of the intracranial contents, the brain could rebound forcibly forward striking the frontotemporal junction against the sharp margins of the sphenoid ridges with possible cerebral contusions or lacerations to the frontotemporal junction resulting in an intracerebral clot.

Recently a car was struck in the rear and pushed through a bridge railing. It fell 100 feet to the ground into the yard of a foundry at an estimated speed of 53 m.p.h. The car landed on its rear end. The driver, a thirty-four year old, 270-pound male, was not wearing seat belts but did have a head support. He claimed he held tightly to the steering wheel during the fall and probably had his head on the head support. He was not unconscious and did not complain of any neck pain. His only injury was a fracture of the right humerus.[29] Time and careful clinical examinations will provide the answer as to whether such a specific safety feature could possibly cause serious injuries when the head is not in direct contact with the head support.

SUMMARY

Case histories of five automobile accident survivors have been presented in detail. Each of these individuals wore a lap seat belt the use of which in most cases probably saved the occupant's life.

Emphasis has been placed on the treatment of these patients by a coordinated multidisciplined team which helped them recover, but in so doing the team also noted new types of injuries related to the lap seat belt restraint.

The findings of this study suggest that although the patients' lives were saved, the further advance of lap and shoulder belts might have provided additional protection and completely prevented any serious injury.

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Geographic Pathology

Editorial Comment: The information contained in this interesting presentation may seem unrelated to the practice of medicine in Michigan. Nevertheless, the subject is interestingly presented, and as made abundantly clear by the author, such terms as "tropical disease" are no longer geographically oriented. We also are given a clearer insight into some of the medical problems that our advisers face in distant lands.

— George Lowrey, M.D., Scientific Editor

BY JOHN T. HEADINGTON, M.D.
ANN ARBOR

Introduction

Geographic Pathology attempts to describe disease within certain geographic areas, to seek causes of disease, and to find reasons for distributional differences. In the past, Geographic Pathology has been defined as part of a much larger body of Geographic Medicine in which Pathology supplements and complements Geographic Physiology, Biochemistry, Microbiology, and other sciences. Avtsyn[1] expanding the temporal dimension adds that Geographic Pathology "includes not only diseases in their initial stages, but also premorbid conditions, i.e., distribution of homeostasis which sooner or later provoke disease."

For the definition to be complete, however, there must be included consideration of those conditions which disturb the normalcy of the human external environment, notably, war, industrialization, urbanization, cultivation, and pollution. These are of equal or greater significance to the total community than the random disturbances or internal environment to which they may be ultimately related.

Political, religious, social, and cultural institutions, therefore, may affect geographic differences in disease as significantly as do temperature, altitude, and humidity. Consequently, instead of remaining restricted by a disciplinal perspective which has been limited to the physical and biological sciences, Geographic Medicine and Geographic Pathology must now also take full measure of the useful contributions of the social sciences: Political Science, Economics, Sociology, Psychology, and Anthropology. One needs only to ask what cultural and social bias determines the effective utilization of health services in any geographic area in order to appreciate that complete understanding of the community is important not only for determination of patterns of disease but also for delivery of health care.

The Geographic Pathologist, as a contributor to Geographic Medicine, is but one member of a diverse team whose combined effort seeks the whole truth.

North Thailand: Geography, People, and Climate

North Thailand is a region of densely jungled parallel mountain ridges verging numerous streams and rivers which wind southward eventually to empty into the Gulf of Siam. These turbid waters interconnect a series of level-flooded basins of varying width and length. Thai-speaking peoples for many years have farmed the rich argricultural lands of the major intermontane basins, and although Northern Thais have some linguistic differences from others in central and peninsular Thailand, they are closely related by similar religious, economic, governmental, and social institutions. At the present time, even regional differences are in transition toward greater uniformity as communication, education, and transportation continue to improve.

In contrast to the relatively narrow river valleys, the wide-ranging and rugged mountainous areas are sparsely populated. Some 20 different tribal peoples in these mountains, numbering upwards of 200,000, from three main ethnic groups: Tibeto-Burmese, Wa, and Yao-Meo-Pateng.[2] Until very recently, these hill tribes of North Thailand were almost entirely isolated from the mainstream of Thai culture and institutions. They had been largely left to themselves, free to pursue their slash and burn agriculture with high-grade opium as the most important cash crop. Until recently, perennial lack of official concern for the northern and northeastern hill tribes has been in some

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ways reminiscent of deficiencies of French colonial policy in Indochina which were so successfully exploited by Ho Chi Minh shortly after the 1954 cease-fire.[3]

Ho's success in obtaining the support of the large number of ethnic minorities of North Vietnam (estimated 2,500,000 in North Vietnam compared with Thailand's estimated 200,000), has not been overlooked by Communists responsible for indoctrinating tribal peoples in Thailand and in Burma. It has therefore become both emergent and expedient to gain the support and allegiance of the Thai border-dwelling hill tribes. Accordingly, border police and ARD (Accelerated Rural Development) teams are providing some simple health services and instruction in sanitation practices as examples of the government's concern.

Unfortunately, the results of years of neglect do not disappear overnight with the declaration of good intentions, and there is reason to believe that the current crash programs are already 5 to 10 years behind if not in some instances altogether too late.* A liberal lashing of instant medical care may only exacerbate the situation if a continous and long-term program of health services is not provided.

The natural north-south distribution of the river valleys has been responsible for the north-south projection of most important highways and railroads. Good all-weather east-west roads in the north are mostly lacking altogether or are still under construction. The absence of these cross-connections and small feeder roads has been one of the most serious obstacles in overcoming the prolonged isolation of mountainous communities.

The preservation of considerable genetic homogeniety within the hill tribes as well as in many of the remote Thai-speaking villages has been an important biologic consequence of the many years of rural isolation. These groups now provide population geneticists with some extraordinarily fertile opportunities for determining the incidence of a number of genetic markers such as blood groups, haptoglobins, and abnormal hemoglobins. With the extension of genetic studies, it is anticipated that there will be substantial changes in theories of ethnogenesis of tribal groups throughout mainland Southeast Asia.

The climate of North Thailand is moderate and generally pleasant the year around, although it is considerably more variable than that of the central plateau or the peninsular coast. Seasonal monsoon winds are the most important influence on weather; local geography may cause differences in rainfall and temperature within a more general pattern. Four seasons can be defined meteorologically, but they tend to merge indistinctly and variably without the abrupt seasonal changes which are typical of northern temperate zones.

During November to February, winter comes when the wind shifts to the northeast and masses of cold air begin to surge south from China. This cold dry air gradually results in termination of the rainy season. The hot summer begins in late February or early March when the daily maximum temperature may climb into the nineties or higher. Humidity falls. Mountain streams dry and rivers shrink. Vegetation sears and many trees lose their leaves in a curious reversal of foliage patterns in contrast to the temperate zone spring. When the fields and forests dry, thousands of fires burning night and day in the paddy fields and mountains fill the air with smoke and fine ash to produce an atmospheric haze which extends upward for thousands of feet as a blanket over the whole of north and central Thailand.

In May or early June warm moist air from the Indian Ocean begins to flow over the hot land as winds shift to the southwest and then rain begins to fall to clear the air and freshen the landscape. The first anticipatory rains are known as mango showers and are prized by orchardists for the salutary effect on the mango and lumyai crops. Rains gradually increase in frequency and intensity until sometime in September when rivers begin to crest in the far north. If flooding occurs, as it frequently does in October and November, there is always the threat of typhoid and cholera. But like the annual beneficence of the Nile, the summer monsoons provide the abundant water and repeated flooding which is required for growing paddy rice, the sustenance of the villager and the most important export of Thailand's agricultural economy.

A period of transition between the end of the Southwest monsoons and the beginning of winter occurs with a shift to the northeast monsoons and extends through October and November with moderating temperatures. This is the time of the rice harvest and numerous festivals.

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*Bangkok Post, July 26, 1967

In spite of the lack of extremes, the changes in seasonal living habits significantly affect the patterns of health and disease. In the north during the winter when nocturnal temperatures may reach 5-10°C., many children are seriously burned when clothing, bedding, and mosquito netting are accidently ignited by open fires or spilled kerosene lanterns. As the rainy season develops, mosquito-borne diseases increase, particularly dengue, hemorrhagic fever, and viral encephalitis. The rainy season is also the time for exacerbation of malnutrition as protein foods are depleted and supplies of fruit and vegetables are at a low ebb.

A careful study of enteric infections in Chiengmai,[4] the largest city in North Thailand, showed that food poisoning and dysentery were most frequently seen in the interval from May to September. Amoebic dysentery was most common during the late hot dry season of April, May, and early June. It was concluded that the incidence of enteric diseases showed some correlation with the rising mean temperature and the developing rainy season, and that this appeared to be less associated with decreased water sources than with increased intake and carelessness in selection of liquids. It was also found that rain-diluted water tended to enhance the survival of enteropathogens. The monsoon rains, therefore, contribute to the seasonal incidence of these infections.

Not only is variation in rainfall an important factor in the epidemiology of some infectious diseases, but it is also of critical importance to rural people who do not live near all-weather roads. During the rainy season many remote areas in north Thailand are completely isolated except by air or foot travel. At this time of year, acute medical and surgical problems in remote villages remain untreated. The hardship of this seasonal isolation is emphasized by the observation that when it is at all possible some rural patients will overcome great difficulties to reach the modern facilities of the Chiengmai University Medical Center: A woman with a 10 kilogram ovarian neoplasm walked over jungle trails for three days to reach the nearest road in order to ride by public bus for another 18 hours; a man with acute peritonitis due to perforation of the small intestine from primary lymphosarcoma was carried several kilometers by bullock cart from his isolated village to a road where he was placed on a bus for a six hour trip to the hospital. The impact of a new medical institution on rural health care in a developing country can practically extend only as far as the rural roadhead. Whether or not it reaches that far is a responsibility of the institution and is dependent on the available resources.

Some Diseases of Special Interest

Tropical medicine has come to be a Geographic misnomer, a restricted and anachronistic term, having its origin in the days when a medical visit to the tropics by a European meant tse tse and elephantiasis, cholera and guinea worm. Stanley and Livingstone. It has been characteristic for schools of tropical medicine in the temperate zones to mostly emphasize parasites and microbes found between Cancer and Capricorn. Tropical countries might just as well set up schools of "temperate medicine" to selectively teach diseases uncommon in the torrid zone. A recent *omnium gatherum* of tropical medicine[5] devotes all but 36 of its 931 recently revised pages to infectious, parasitic, and arthropodal diseases. The fault is a matter of bias and emphasis which tends to restrict a proper view of the whole: genetic defects, neoplasms, degenerative diseases, and many other conditions are equally important as infectious disease and may be as geographically specific.

Tropical diseases of special interest are, therefore, usually special to the visitor, but are not necessarily special to the local practitioner who may be all too familiar with them. Nevertheless, some of the following are of unusual interest even as measured by the parochial eye.

CHILDHOOD MALNUTRITION: Severe Protein-calorie malnutrition was not considered a significant problem in Thailand until quite recently. The first cases were reported from South Thailand in 1955.[6] In 1966, Thanangkul and Witaker[7] reviewed more than one hundred northern Thai children with varying degrees of protein calorie malnutrition admitted to the pediatric wards of Chiengmai University Hospital during 1964. They firmly established childhood malnutrition as an important disease in this area.

Childhood malnutrition is becoming a disease more and more characteristic of the demographic crisis as birth rates remain high and infant mortality decreases. Kwashiorkor and other clinical forms of severe malnutrition have been aptly called the disease of the displaced child — the infant who is displaced from the breast because of the necessity to feed the next born. Childhood malnutrition may also be a disease which follows cultural disintegration: for many years in certain parts of Africa, polygamy was a very effective form of birth control because it was a cultural taboo for a wife in a polygamous family to conceive within two years of the birth of her last child. This practice effectively spaced children at least two years and nine months apart and thus permitted a long interval of breast feeding.

The majority of Thai children with severe malnutrition are between one and two years. After removal from the breast they are placed on a weanling diet usually deficient in both protein and calories, which if prolonged results in severe retardation of mental and physical growth with wasting and apathy. There is probably also decreased immunoresponsiveness to infectious disease, and the common heavy infestation of intestinal parasites often exacerbates the underlying condition. Death from intercurrent infection is the rule. Prevention and treatment are the combined problems of population control and nutritional education.

THYROID DISEASE: North Thailand is an area in Southeast Asia in which iodine deficiency goiter is endemic. A recent study of surgical diseases of the thyroid in north Thailand,[8] before widespread iodine prophylaxis, revealed some striking similarities when data were compared with those from Michigan during the pre-iodine era.[9] This study confirmed a low incidence of lymphoid infiltrates in thyroid glands from a geographic area deficient in dietary iodine, a low incidence of lymphocytic thyroiditis, and total absence of Hashimoto's thyroiditis. Compared with a population in Michigan before iodine prophylaxis, there was a much higher incidence of adenoma and a much lower incidence of diffuse glandular hyperplasia. It was of considerable interest that the incidence of carcinoma of the thyroid in northern Thais was almost four times than that observed during the preiodine prophylaxis era in Michigan 40 years before. This suggested the possibility of a world-wide increase in thyroid carcinoma in recent years.

GENITAL TRACT CANCER: The incidence of most neoplasms of the male and female genital tract in north Thailand is approximately the same as for other areas of Southeast Asia.[10] In general, compared to the United States, there is a high incidence of squamous carcinoma of the penis and uterine cervix with low incidence of adenocarcinoma of the prostate and body of the uterus. In Thailand, as in other parts of Southeast Asia, there is also a strikingly high incidence of trophoblastic tumors. According to Novak,[11] the incidence of molar pregnancy in the United States is about 1:2500; in Chiengmai Province of north Thailand the incidence is about 1:300.[12] A provocative study from the Philippines where there is a similarly high incidence has suggested that disturbances of trophoblastic tissues may in some way be related to deficiencies of human nutrition.[13] Thus far, however, there is little more than statistical and empirical evidence to support this interesting postulate.

EOSINOPHILIC MENINGOENCEPHALITIS: A severe and potentially fatal parasitic infestation of the central nervous system may follow accidental ingestion of infective larvae of a metastrongylid rat lung worm, *Angiotrongylus cantonensis*. Recently detected in large numbers in Thailand,[14] the parasite has been reported since 1957 as causing eosinophilic meningoencephalitis in man in Australia, China, Formosa, Guam, Hawaii, Ponape, New Caledonia, Saipan, and Tahiti.[15] Although suitable intermediate hosts are probably widely distributed, the human incidence is low because of the requirement for ingestion of a planarium or raw mollusk, usually a snail or slug. Cerebral symptoms may be quite variable and even suggest the possibility of psychosis or a space occupying lesion. The finding of numerous eosinophils in pleocytic spinal fluid from a potentially exposed patient indicates the possibility of angiostrongylus infection. Similar findings have been described in cases of cerebral infection with *Gnathostoma spinigerum*.[16, 17]

BARTONELLA-LIKE ACUTE FEBRILE ANEMIA: In 1966, Whitaker[18] described an acute febrile anemia associated with Bartonella-like erythrocytic structures. Bartonellosis, until the time of this communication, had been remarkable for its greatly restricted distribution in western South America. Three previously well Thai males were described as having continuous fever, malaise, hepatomegaly and pallor with a severe and rapidly progressive hemolytic anemia. Erythrocytic structures similar to Bartonella organisms were found. Although the relationship of this hemolytic syndrome to Bartonella species has not yet been established beyond doubt, similarities to

Oroyo fever are striking and at least one additional patient has been seen with similar findings since publication of the first report.

SEGMENTAL GANGRENE OF THE SMALL INTESTINE AND MESENTERIC ADENITIS IN CHILDREN: Early in 1967 there appeared a report of segmental gangrenous infarcts and mesenteric adenitis in Northern Thai children.[19] The typical clinical features in young children were: abrupt onset of low fever, diffuse abdominal pain, vomiting, a severe watery diarrhea with feces strongly positive for occult blood, then onset of paralytic ileus followed by peripheral vascular collapse. After review of a necropsy in clinico-pathologic conference the correct diagnosis was subsequently made in three additional children who survived following segmental resections of the small intestine. Although there are some features of this condition in common with "pig bel" enteritis as reported by Murrell[20] from the highlands of New Guinea, we have so far been unable to recover a Clostridium species from a small number of more recent cases. A seasonal distribution now seems likely as no new cases were observed until onset of the rainy season. The etiology remains obscure.

GASTROINTESTINAL ANTHRAX: Cutaneous and pulmonary anthrax, the most common forms in the United States, have usually appeared as occupational diseases in workers processing hides and animal hair imported from endemic areas. Gastronintestinal anthrax is almost always a result of eating improperly cooked meat from an infected animal. After ingestion of the live organism there develops a severe acute phlegmonous inflammation of the bowel, usually the terminal ileum and colon. This enteric form of anthrax is occasionally seen in north Thailand in the form of small epidemics as several individuals share the meat of an infected water buffalo or bullock. Good data are not available, but the general impression is that case mortality is very high, even in the face of massive antibiotic treatment.

PHYSICAL TRAUMA: In any rural area various forms of physical trauma have always been a significant contribution to disease. In north Thailand, traumatic events sometimes occur on a large and dramatic scale, such as a recent opium war in which, "300 former Kuomintang irregulars were killed . . . in a bitter battle between two armed Yunnanese bands over opium smuggling profits in the area where the borders of Thailand, Burma and Laos meet."*

Villagers are still occasionally mauled by hungry tigers and hunters gored by angry elephants. But times are changing, the jungle is receding, and the placid pace of the Thai water buffalo is giving way to the staccato dash of the Japanese motorcycle. What the Model T Ford was to the rural United States 40 years ago, the Honda is to rural north Thailand in the 1960's. The incidence of death and injury due to motorcycle accidents is a serious problem as traffic laws are something for a more conservative future and hundreds of "learners" having their first real taste of the machine age careen wildly along in great good humor. Forensic Pathology has its special geographic emphasis as well.

Geographic Pathology and Medical Education

Determination of geographic differences in disease is necessary for planning and revision of the mode and content of a medical school curriculum, for directing the emphasis of medical research toward the reality of urgent and remediable human problems, and for proper orientation of service facilities to specific needs within existing economic limitations. Appreciation for such differences when planning a new medical school in a developing country in which resources are limited can help direct the new institution to a truly realistic and useful relationship to the community which it is to serve. The question of relevancy of institutions, both functional and economic is particularly pertinent to the underdeveloped areas of the world. A medical school which abstains either by default or design from direct involvement with community health needs becomes an academic luxury few developing nations can afford. This view by no means excludes a tolerable concern for molecular biology, but there is a definite requirement for proper emphasis and priority.

The importance of geographic differences in disease to medical education was indirectly illuminated by Ledley[21] writing about computer aids to medical diagnosis. He pointed out that diagnostic probability depends on consideration of two factors (a population factor and a pathophysiologic factor): "The first is the probability that a patient being seen by a physician has (a certain) disease before his symptoms are observed." This population factor includes such important variables as geographic location, genetic factors, seasonal changes, epidemicity, endemicity, as well as cultural and socioeconomic differences.

By illustration, a properly oriented medical student in north Thailand, in contrast to his equivalently trained counterpart in the midwestern United States, knows without seeing the patient that bloody diarrhea is more likely to follow amoebic rather than ulcerative colitis; that the cause of hydrops fetalis is more likely due to the presence of Bart hemoglobin than RH isoimmunization; and that peripheral neuropathy is probably a result of B vitamin deficiency rather than a complication of diabetes mellitus. Some of these population factors, particularly information about infectious disease, are continuously changing, and this highly dynamic state requires an open-ended curriculum in which today's necessary information is replaced by; not supplemented by, tomorrow's.

The pathophysiologic factor is the second upon which diagnostic probability depends. This factor, independent of the constantly changing geographic variables, presumes that observed signs and symptoms are the result of more or less specific and unchanging structural and physiologic phenomena: aortic valvular stenosis has potentially similar pathophysiologic consequences whether it is developmental or postrheumatic; the molecular basis for a hemoglobinopathy is unaltered by its detection in an Asian or European.

The sum of these two general factors, population and pathophysiologic, can be used to determine the content of the curriculum. Special consideration of these factors, therefore, makes it possible for a medical school to be unique if it is decided that the institution shall be relevant to a specific community, whether local, regional, or national.

A knowledge of geographic differences in disease can also be useful in determining the mode of the curriculum, because the teaching methods should be directed to the real problems facing the new graduate. For example, there should probably be a considerable difference in curricular mode if the average graduate is expected to be the only medical authority totally responsible for the health care of thirty or forty thousand illiterate and superstitious villagers in the rural isolation of some developing country as compared with the average graduate who anticipates a highly restricted private practice of some medical specialty in an urban area of the United States. Administrative skills and economic perspectivies of an entirely different magnitude are required of the graduate of the developing country. He may have to learn how to establish priorities for services in order to do the most good for a selected portion of the population within severe economic limitations and without much regard for the traditional physician-patient relationship.

If there is a physician-population ratio of 1:20,000, it is clearly pointless with respect to the community as a whole, if the only physician available restricts his practice of medicine to those patients he can treat personally, all good intentions and 18 hour days not withstanding.

In addition, although there is much to be known, the curricular mode must also take advantage of teaching methods which bear upon how students learn. It is predictable that medical students in different parts of the world subject to important cultural and social differences will not respond uniformly to any single teaching device. As with geographic differences in disease, some knowledge of these modal factors in education can promote the uniqueness and relevancy of the indigenous institution.

With few exceptions, however, neither the content nor the mode of traditional (Western) medical education adequately prepares medical graduates to deal effectively with many of the problems as they really exist in some developing countries. The idea that the simple explant of any archetype western medical school selected for its "excellence" will automatically provide any other part of the world with equivalent excellence is slowly beginning to be recognized as a superficial and undesirable generality.

The visiting pedagogue to the developing nation is, of course, also subject to many geographical and educational differences. Although his lectures and discussions may be scientifically accurate and factually up-to-date, he may be a hemisphere re-

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*Bangkok Post, August 3, 1967

moved from what is locally important. In addition, his background of technologic and personal affluence may be more hindrance than help unless he learns to use facilities and services which are actually available rather than proposing as a solution to local problems the acquisition and development of what he is accustomed to. This can be an exceedingly difficult adjustment.

Finally, Geographic Pathology may also take into consideration the various stages in the natural history of disease as it occurs in the community and emphasize the inclusion of this information into the medical curriculum. An appreciation for the predominant stage of a disease can potentially influence many aspects of institutional planning and service. Haagensen[22] in his text, *Diseases of the Breast,* observed that one of the most important factors in predicting the presence of auxillary metastases in breast cancer, and hence survival, is the socioeconomic status of the patient He pointed to the significantly higher incidence of metastases in patients admitted to charity wards as compared with those admitted to private services. The moral issue facing medicine which is implied in these data is clear enough. The magnitude of the problem, however, in a poor and semiliterate population which has either minimal health knowledge or none at all is truly enormous. In north Thailand, about 90% of women with breast cancer have axillary metastases when first seen by a physician. In such a population, at least in the early phases of development of medical services, breast cancer is primarily a problem of public health education and not one of providing multiple sources of cobalt 60 for palliation.

In summary, knowledge of geographic differences in disease can help determine the relevancy of institutions responsible for the health of the community, and if modern medicine is to meet the demands of the future, it must above all else be responsive to the reality of human needs.

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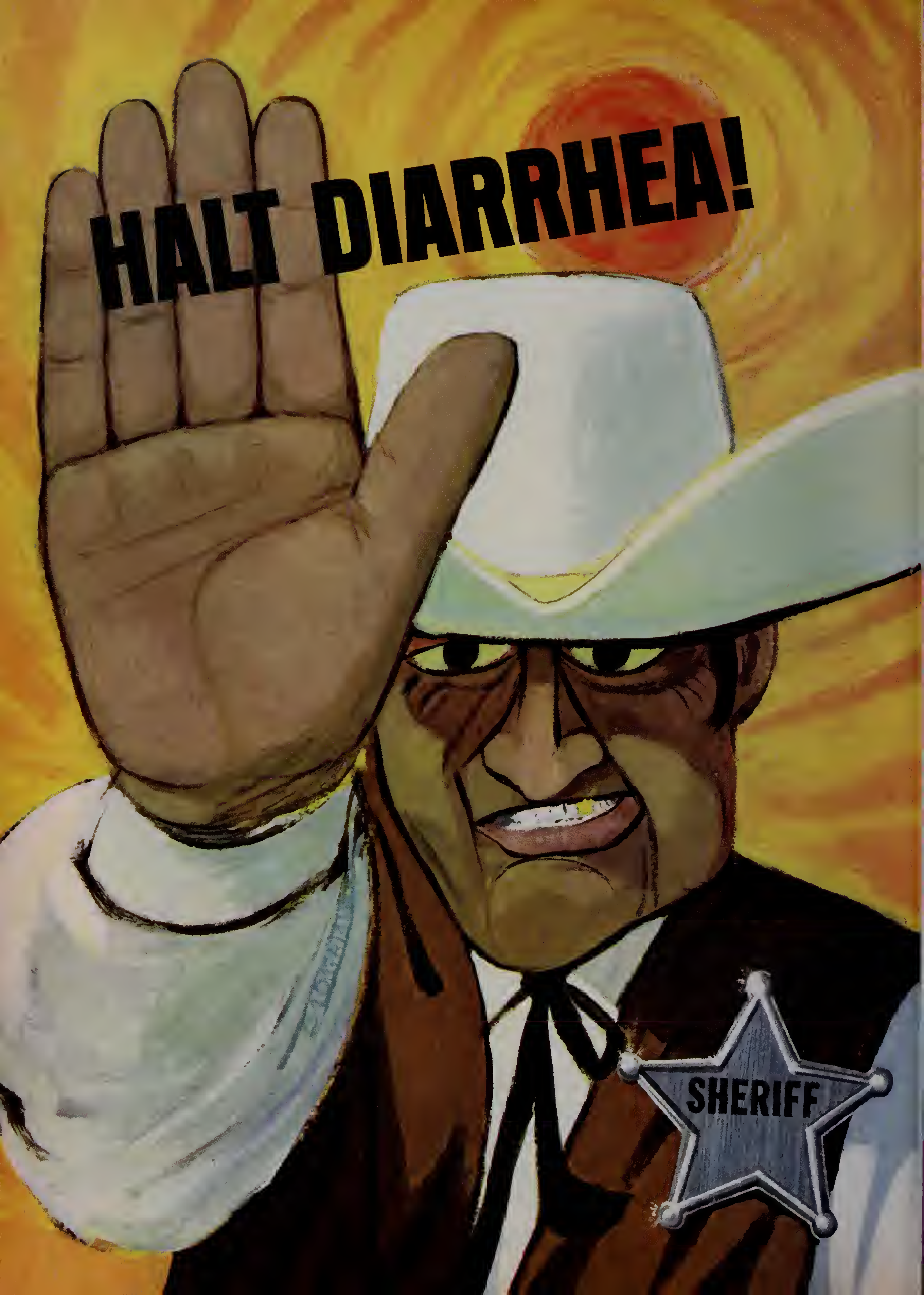
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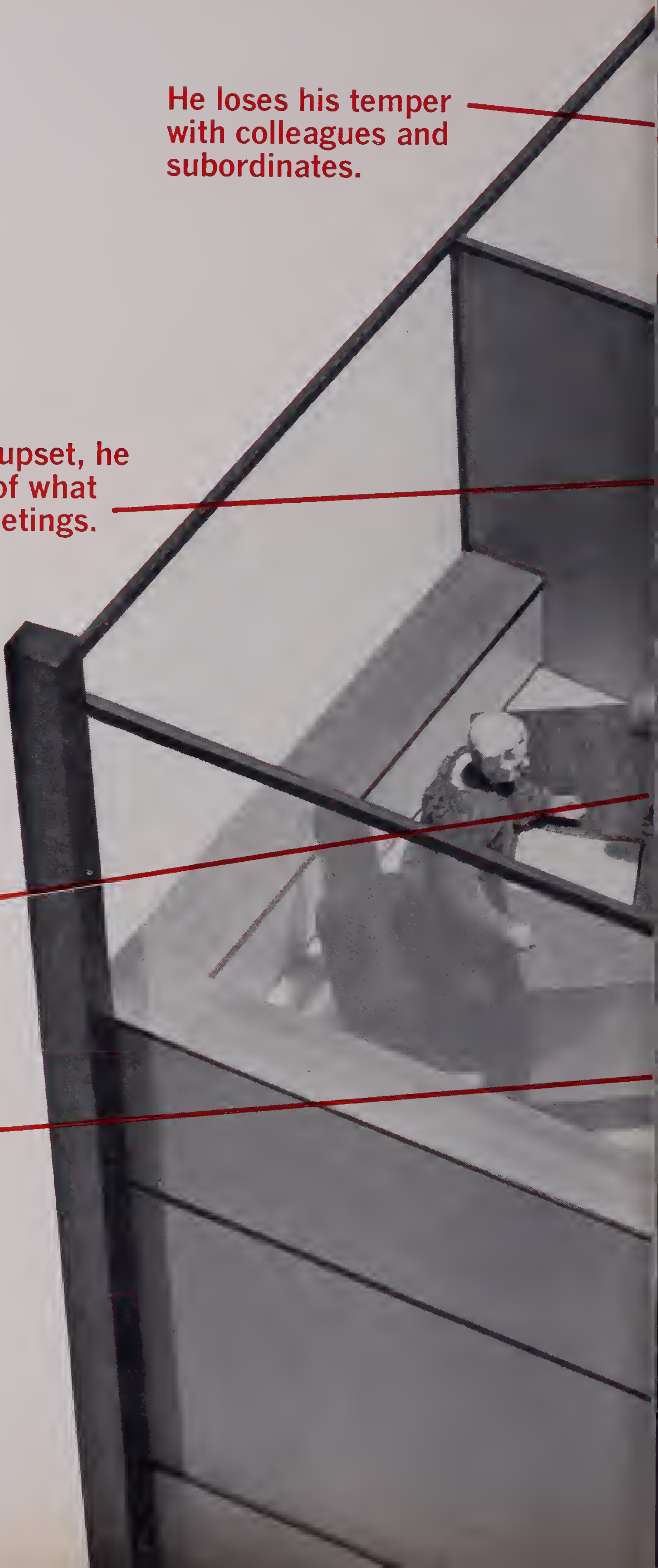

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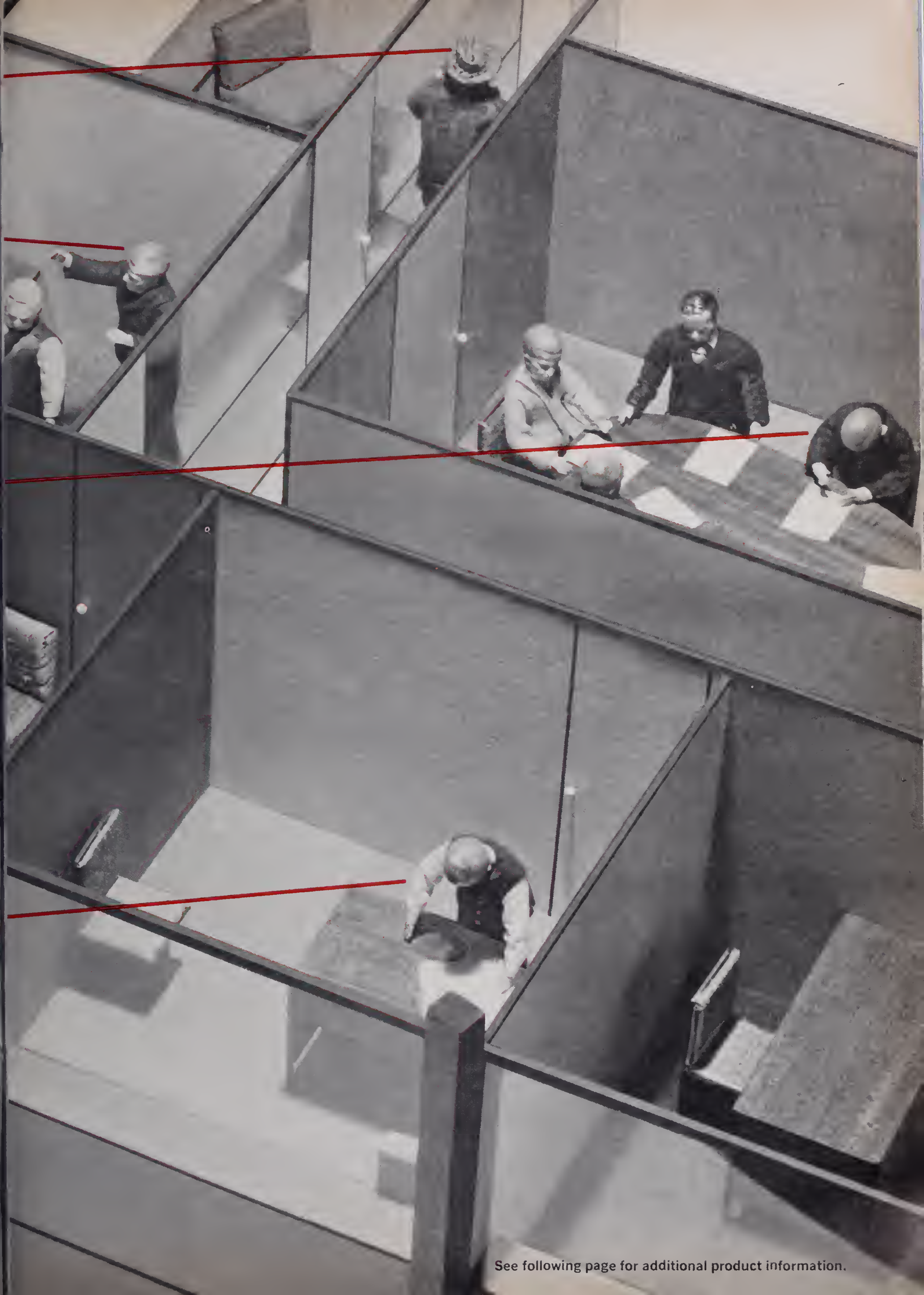

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The Emergency-Room Psychiatrist; A Report During the Detroit Riot

BY LARY R. BERKOWER, M.D.
DETROIT

ABSTRACT — The emergency room psychiatrist, ordinarily a resident, fulfills a vital function in making emergency evaluations and dispositions of acutely disturbed patients in a large city hospital. A description of emergency room practice at Detroit General Hospital during the July, 1967 riot is provided. Several cases are presented illustrating how the riot situation aroused unbearable instinctual forces in patients with weakened egos. These forces were unsuccessfully defended against by the patients' psychopathological defence mechanisms. Considerations in the evaluation and disposition of these patients are discussed.

One of the least recognized, yet very relied upon figures in the medical community of a large city is the psychiatrist, ordinarily a resident, working in the emergency room of the metropolitan hospital. He is responsible for making dispositions upon urgent psychiatric problems, and often he is the only person in the city in a position to do so. In the midst of all the turmoil of a crowded emergency room immediate evaluations and decisions must be made by him concerning emotionally disturbed patients which may have lasting consequences to them and their families. It should be added that the duties of the emergency room psychiatrist preceded the present era of community psychiatry, and from all indications, there has been no reduction in the need for his services.

Thus, the physician in the city with an acutely agitated patient requiring immediate psychiatric attention knows to whom he can turn at all times for help.

From the viewpoint of the psychiatrist in the emergency room of a busy city hospital, such as Detroit General Hospital, this work is a challenging and hectic experience. One encounters almost every form of psychopathology described in textbooks over a short period of time. Such entities as Korsakoff's psychosis, waxy flexibility, and acute alcoholic hallucinosis are relatively familiar sights in the emergency room, though rare elsewhere. Psychologically, the variety of ways people deal with overwhelming feelings and life situations is a constant source of surprise despite many years of training. Of course, any prevalent disaster in the hospital area increases and compounds the pre-existing degree of challenge to the psychiatrist in the emergency room.

THEREFORE, WHEN MY 24-hour tour of psychiatric duty occurred during the massive Detroit riot of the week of July 23, 1967, I was unusually eager to grapple with the acute emotional reactions which would surely arise. How, I asked myself, would the rampant rioting, burning, looting, and sniping color and precipitate disturbed forms of behavior requiring immediate psychiatric attention? The following are some of the observations I made during this unforgettable period at Detroit General Hospital.

To begin with, the hospital was surrounded by national guard and army troops on all sides, some of whom were holding prominently their guns and bayonets. Many Detroit policemen were also present, especially since the hospital is located downtown opposite the main city police station. Reporters, photographers, and newscasters were seen all around the hospital. At the ambulance entrance, as a part of the disaster plan in force, cots were lined up so that injured victims could be brought into the emergency room more quickly. Doctors, nurses, and hospital aides were waiting outside throughout the night to receive patients.

Thus, the busy atmosphere about the hospital had an unusual, sensational quality; everyone knew that they were a part of the national news of the day. In spite of all the police and federal protection a certain degree of peril seemed to be

Continued on Page 206

Doctor Berkower is a graduate of Wayne State University Medical School. He interned at Sinai Hospital, and then served two years in the U. S. Air Force, stationed at Selfridge Air Force Base. He began his psychiatry residency at Detroit Psychiatric Institute, which is the psychiatry department of Detroit General Hospital, in September, 1965.

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holding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. It is usually unnecessary to exceed 4 tablets daily. A trial period of 1 week is adequate to determine response; in the absence of a favorable response, discontinue. Maintenance: An effective level is often achieved with 1 or 2 tablets daily, do not exceed 4 daily. 6562-VI(B)R2

For complete details, please see full prescribing information.

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present raising the level of tension, since snipings and rumors of snipings were occurring every hour in the city.

RIOT VICTIMS FILLED the rooms and halls of the emergency area. Most of them were suffering from gunshot wounds, burns, and lacerations. Patients, both perpetrators and victims of the riot, were crying out in pain while receiving intensive medical attention. The instigators of the riot were easily distinguished by their handcuffs and leg restraints, since they were police prisoners. Some of them were addicts suffering from withdrawal symptoms. At times television photographers were taking films while the doctors and their assistants were at work. One could view the familiar hospital personnel on television later in the day on news programs.

Though staff fatigue was obvious, everyone seemed to be functioning on a special reserve of physical and psychological energy with no loss in efficiency. Detroit General was operating under its disaster plan, which contributed to the overall success in meeting the emergency needs of the community. In addition, many members of the outside teaching staff of the Wayne State University Medical School converged upon Detroit General during this period, and actively participated in patient care. Although Detroit General is the main teaching hospital of the medical school, the presence of so many noted practitioners at one time was unusual, as well as very beneficial.

During all of this, psychiatric patients trickled into the hospital. Those suffering from comparatively mild anxiety reactions were screened by the medical staff, calmed, and provided tranquilizers where this was considered necessary. The more severely disturbed patients were seen by the psychiatry resident in charge. Some of the remarkable emotional reactions precipitated by the riot which I encountered include the following:

AUTHOR BERKOWER

THE FIRST PATIENT of the day was a 22-year-old single male (Mr. D.) who had been intercepted by the police after wandering in and out of the hospital building. At one time he was seen roving through the corridors of the fourth floor of Detroit General. In the past he had been treated as an outpatient by another hospital in our area. Mr. D. openly stated he was an FBI agent and was in search of snipers. When he was processed by the administrative staff he threw his draft card on the table and claimed this was his FBI identification. During our interview he refused to discuss what brought him to the hospital, maintaining he was an FBI agent and should at least have representation by his lawyer. The patient appeared as a confused, distant, and fearful individual with loosened thought processes compatible with schizophrenia.

It was my impression that Mr. D. had defended himself from the stresses and lawlessness of the riot situation by withdrawing from reality and entering his delusional world as an FBI agent, thus surmounting his impulses. Yet there was a sufficient amount of reality testing present that enabled Mr. D. on his own to come to the hospital where psychiatric help could be obtained. Under the circumstances I had no choice but to hospitalize this disturbed individual.

ANOTHER UNUSUAL RESPONSE to the riot atmosphere was that of a 17-year-old girl (Miss O.) who was living in common law with a 21-year-old man not far from the center of the city disorder. The girl had been raised in foster homes and had received previous psychiatric treatment. She and her boy friend had quarreled the previous night, and the patient had briefly left their apartment afterward. The next day, while her boy friend was working, three small fires broke out in their apartment. Little damage resulted since they were quickly put out. After one of the fires Miss O. telephoned her friend urging him to return to her immediately. The patient was first seen by the police department, which referred her to our hos-

Continued on Page 208

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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pital. When I talked to Miss O. she insistently denied setting the fires. She appeared alert and coherent, though there was a sad and bewildered quality to her affect. Therefore, I contacted her neighbor who presented unmistakable evidence that the patient was the only person who could have caused the fires; the neighbor was understandably frightened by Miss O. The patient persisted in her story when I confronted her with this, though she wept. I concluded that some psychological dissociation and regression had occurred in this emotionally immature young lady leading to her behavior and amnesia. The more usual suicidal gesture by ingestion or wrist slashing was replaced by the fires under the influence of widespread arson in Detroit. Miss O. was hospitalized overnight while a "rescue" by her boy friend took place and she stabilized (with appropriate psychiatric counseling) away from her charged environment.

A THIRD TYPE of reaction to the riot was that of a 40-year-old married white cab driver and property owner with no previous psychiatric or criminal record. He was a police prisoner after having been arrested for carrying a weapon while walking on his street. The patient, Mr. M., insisted this was for self-protection, and he was innocent of any wrongdoing. While in his jail cell with seven other prisoners, some of whom were arsonists, looters, and snipers, Mr. M. went into a panic. He started trembling, became short of breath, cried, and fainted. Marked anxiety was still present when I interviewed him in the emergency room. I was able to help Mr. M. relieve much of his acute anxiety by letting him ventilate his pent-up feelings of having been wrongfully accused by the police and his fears concerning the other prisoners, who were largely negro. Mr. M. related much of his panic to his childhood when he was afraid of being beaten up by bullies on his block. After the twenty-minute interview the patient was sufficiently relieved that he could return to his jail cell quite calmly.

THE FORM OF psychotic denial of reality and delusions during the riot period was interestingly affected by the surrounding civil disturbance. Thus a 40-year-old separated lady with a long history of schizophrenia wandered into the hospital in search of her six children. They had been placed in foster homes several years before due to her illness. The lady, Mrs. S., was convinced her children were in Detroit General Hospital, and she wished to reclaim and save them from the chaos. While I talked to her she hallucinated a son before her eyes, as if fulfilling her wish by transforming illusion into reality.

Another 36-year-old lady with a four-year history of mental illness started fasting and not sleeping during the riot. She heard voices of people wanting to kill her, and she contrasted this with her "love of humanity." This lady became frightened when an aide passed by during our interview because she was afraid he would shoot her. In this manner the patient warded off and projected her own forbidden aggressive feelings. One more reaction to the riot was that of a 17-year-old girl who went into a catatonic stupor as a result of overwhelming impulses provoked during the riot.

In these and many other ways the psychological impact of the riot was to arouse in patients with weakened egos unbearable instinctual forces. These were unsuccessfully defended against by such psychological mechanisms as denial of reality, dissociation, regression, projection on to others, and withdrawal into delusional thinking. The experience of treating these patients during this traumatic period was an exciting and memorable one. Serving with the rest of the dedicated and united staff of Detroit General Hospital as emergency room psychiatrist was a rewarding opportunity.

Before prescribing, see complete prescribing information in SK&F literature or *PDR.* A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
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Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

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or all-night relief
of nasal congestion

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Where Does MSMS Stand re Legislation, Forensic Medicine, Laws, Regulations?

The MSMS publication *Where We Stand* points out some questions which need answers "some in the very near future" and this may especially be true in the area of legislation, forensic medicine, laws, and regulations governing medicine.

The booklet, written this past summer by Hugh W. Brenneman, MSMS executive director, has been studied by The Council and The MSMS House of Delegates.

The booklet covers 13 subject areas and three have already been reprinted in the December and January issues of *Michigan Medicine*. Other sections will follow.

The booklet is helping to serve as a guide for the Michigan Health Information Research Institute, which was authorized by the 1967 House of Delegates. The independent institute is to be established "to obtain correlate and report upon research in the distribution of health care."

The *Where We Stand* workbook has been described as "an analytical overview of some of the current concerns and activities of MSMS and related, emerging, unanswered questions."

The chapter in the booklet on "Legislation, Forensic Medicine, Laws and Regulations Governing Medicine" raises many questions after a discussion of the subject.

The following is quoted completely:

LEGISLATION, FORENSIC MEDICINE, LAWS AND REGULATIONS GOVERNING MEDICINE

Discussion

Enforcement Authority

The MSMS does not have the legal authority to enforce the laws which regulate the profession because it was established for scientific and educational purposes, not for the exercise of legal authority. Because of this, and because all members of the profession in Michigan are not members of MSMS, it cannot stop an incompetent doctor from practicing or discipline a nonmember.

Citizenry Control of Medicine

The profession of medicine as a part of the total society is regulated and controlled by the laws of the state (not alone by MSMS principles) and thus is subject to the will of the citizenry expressed through the license to practice. When legitimate public concern is expressed through the introduction of bills which might affect the manner in which medicine exercises its privilege of practice, MSMS must give such bills the most serious consideration. Otherwise, unduly restrictive laws might be adopted.

Number of Bills Increased

The number of bills affecting the practice of medicine has increased both in number and in scope. The activities of MSMS in providing information and advice to the Legislature have increased. MSMS is having a hard time keeping pace with the accelerated tempo of legislation caused by Michigan's "full-time" Legislature. Although a larger number of physicians read the bills, know something of the laws, and are in a position to obtain and evaluate factual information, understand practical implications, and formulate reasonable legislative presentations, the increase is not significant in comparison with the need. MSMS needs rapid readjustment in this area, particularly to provide for contingencies which require special handling and for back-up staff members to understudy key staff personnel.

Staff Personnel

Modifications of Licensure

MSMS and its members must be both willing and capable of assisting government in making modifications of medical licensure and the legal environment in which it practices and do so for the benefit of all society, not just the profession. MSMS has recognized this in its recent approval of the single medical practice act concept.

Despite various strategies, including the holding of sessions between legislators and doctors from their home towns, the establishment of a first aid service, the preparation of much material for hearings, etc., MSMS needs to increase its efforts in this field just to stay even.

PKU
Measles and TB
Immunization

Also, MSMS is faced with statutes which regulate *portions* of the practice of medicine, such as the PKU law and measles and tuberculosis immunization statutes. Are these in the public interest? Are additional ones to be avoided?

Podiatry
Optometry
Psychology

Health Arts Practice Study

MSMS is concerned about the expansion of practice privileges sought by practitioners of podiatry, optometry, psychology, etc., not because of any additional competition that might be engendered but because the MD is not convinced that these limited licensees can safely practice in expanded areas. This position of MSMS is not generally understood by the public, and the practitioners of these arts have sought in some instances to further confuse the Legislature. A study is being sought in the Legislature which could result in a solution to this problem (see Appendix B for Resolution HCR 88).

Cultism

Allied with this is the responsibility which the profession has taken upon itself to oppose cultism in or outside the Legislature. This becomes especially acute as government enters the picture and arbitrates who can and cannot practice under governmental care programs.

Professional Associations Legislation
—Unrelated Income
—Use Tax on Professional Services

Incidentally, one area of legislation which MSMS feels a strong interest in, and which is now in turmoil, is that involving other professions and professional associations. Legislation or regulation, for example, which would change the tax liabilities of trade and professional associations could have a deleterious effect on MSMS. The same is true of legislation which might extend the Use Tax to professional services.

Progress
National Board of Medical Examiners
Blood Transfusions a Service
Hospital Licensing
Nurse Practice Act

It should also be commented that progress is being made. In 1967 legislation was passed among which were such acts as these: The State Board of Registration in Medicine may now recognize the certificate of the National Board of Medical Examiners; blood transfusion has been legally declared a service, not a sale; a new hospital licensing law (specifically excluding the "franchising" concept) has been passed; the Nurse Practice Act has been rewritten, etc.

Civil Rights
Financial Records and Taxation

MSMS has been very careful to live within the law and its incorporation charter — e.g., it has adhered to the Civil Rights Acts, concerned itself with accurate handling of finances in relation to taxation requirements, etc., albeit at some expenditure in time and money.

Questions

Medical Examiner System

A. Should MSMS develop a statewide medical examiner system for all counties in Michigan and push for its adoption by the Michigan Legislature?

Medical Testimony

B. Should medical expert panels be supplied by MSMS for
   1. Malpractice cases?
   2. Workmen's Compensation cases?
   3. As a service to the court when it is unable to obtain satisfaction in cases of disputed medical testimony?

Future Legislative Needs

C. Should a Legislative Research Committee be established to make a continuing study of future legislative needs of the medical profession in Michigan by the MSMS?

Medical Education for the Legislature

D. Should MSMS conduct a teaching program at its headquarters, recruiting as students key members of government including the members of the Legislature — such a teaching program to cover in some depth the medical subjects where controversy is keenest, e.g., the eye, x-ray, orthopedics?

Group Practice of Medicine

E. Group practice of medicine is growing and raises questions relating to legality of corporate practice. At the same time, the public appears to like group practice under certain conditions. Should a special study be made of the legal as well as the ethical facets of group practice?

---

77 Percent of U-M Research Income from Government

The single largest sponsor of research at the University of Michigan during the year 1966-67 was the U.S. Department of Health, Education and Welfare, according to a recently published summary of U-M research expenditures for the past year. Of the total figure of almost $60 million, HEW provided 15.7 million largely from the biomedical programs of the National Institutes of Health.

A. Geoffrey Norman, U-M's vice president for research, pointed out in the report that much of the support for research continues to come from federal government agencies. The National Aeronautics and Space Administration was a substantial sponsor. Although the funds provided the U-M during the past year from the defense agencies amounted to almost 30 percent of the total expended, this percentage has been steadily declining as the federal research support base has been expanded.

The total of federal funds was $45.8 million, 77% of the total. University funds supplied $5.6 million and other support came from industry, private foundations, health organizations, and other sources.

A breakdown of the distribution of funds shows that the engineering sciences accounted for 31.6 per cent of the University's research expenditures, the life sciences 27.5 per cent, the physical sciences 21.3 per cent, the social sciences 14.8 per cent, and the humanities and others 4.8 per cent. In recent years there has been a substantial increase in the funds available for social sciences, life sciences, and the humanities.

SEE VIETNAM FEATURE, PAGE 248

The story of the Michigan doctors who have served in the "AMA Volunteer Physicians for Vietnam Program" is told vividly in a special feature, beginning on 248. In the photo above, Hugh C. Sulfridge, M.D., Saginaw, is shown with some of the children at an orphanage conducted primarily for crippled children by the Sisters of Charity at Can Tho.

Resolution Applauds Career Recruiting Work Of State Health Council

Michigan school counselors and others who participated in the Michigan Institute on Health Careers held recently near Battle Creek gave the Michigan Health Council a standing ovation for its efforts.

In a resolution adopted by the Institute, the counselors and other guests recognized the need for work in the health careers field.

The adopted resolution began, "Whereas, the problem of shortages in health manpower in this nation is critical and widespread, and whereas the public in general and educators in particular are only partially aware of this critical state and the role they can play in its alleviation; and whereas, the Michigan Health Council has seen the need to bring this problem forcibly to the attention of educators through their counselors the Michigan Personnel and Guidance Association . . ."

The resolution was presented by Mrs. Robert H. Fraser, coordinator, Health Careers Council of Calhoun County.

Togetherness....

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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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MEOO Director Ford Suggests Ways to Break Cycle of Poverty

WM. R. FORD
MEOO DIRECTOR

"It's devastating to an individual to be trained for a career in machine operation only to find out that the hiring restrictions exclude him because he only completed 11 years and 6 months of formal education.

"The system is stacked against the poor and disadvantaged who make up one-half of our urban dwellers.

"The college-bound youth are in a minority, but vocational education is still a nasty word.

"Quality day care must be a priority in every community and it must be done with or without federal funds."

Those are some of the views of William R. Ford, Director, Michigan Economic Opportunity Office.

Mr. Ford has declared that, "The cycle of poverty is indeed one of the most destructive and self-defeating traps which anyone can be a victim of. It breeds hopelessness, despair, alienation, helplessness and defeat.

"If we're honest, we have to admit to ourselves that often we become a part of 'the System' . . . the system that is stacked against the poor and the disadvantaged who make up one-half of our urban dwellers and over one-fifth of our total population in America."

The need for Michigan programs to help the unemployed, disadvantaged is stressed by Mr. Ford. He says, "We live in a most exciting time! Change social and technological, is sweeping our nation and at a rate that would frighten away the meek and the faint-hearted.

Mr. Ford declares: "Every day new problems and new priorities are before us in Michigan and the nation. We must seek to understand the underlying reasons and causes of riots, civil disorder and open street warfare before we can move onward with significant steps in defeating discrimination, poverty and unemployment, conditions which I feel breed discontent, and subsequently result in civil disorders.

"We cannot move too quickly lest by rapid action we forget to listen to those who do not always participate in change. We cannot move too positively unless by forward movement we mean subverting Democracy for a social dictatorship where the people become the secondary motives for our movement."

Day Care, Pre-School

Mr. Ford believes that some of the problems faced by the disadvantaged could be prevented or minimized by better programs in day care and pre-school. In part, he contends:

"One of the significant contributions of the local poverty programs in Michigan has been the institution of Day Care and Pre-School programs for mothers who could not previously find work because of their family responsibilities.

"In addition to releasing mothers for work or training or further education, Day Care has presented pleasant, school-type experiences to hundreds of children who may not have known these experiences without this kind of care.

"Interestingly, again, the poverty program has stimulated other Michigan agencies to look at their selection and education process to see if they were indeed contributing to the needs of our society's children.

"But there has been a less optimistic result of these programs and that is that a great door of hope was opened to thousands of women seeking to get off ADC and welfare rolls — only to have their hopes dashed because the facilities and the budgets were limited.

"Quality Day Care must be a priority in every community and it must be done with or without federal funds. The mothers and the children and, consequently, the future of America rests in the hands of those who can and will contribute to the search for independence and self-sufficiency on the part of those mothers who want to work."

Schools

Mr. Ford declares that "A good share of the future of America rests in the hands of educators, school boards, and local governments." He offers these views of the drop-out problem:

"The school drop-out personality is formed before or shortly after the child starts school. In the ghetto because of de facto segregation through neighborhood schools, the minority child is doubly disadvantaged. He learns soon not to expect much from the "jail" called school and the teachers often return the favor — they don't expect much from him, and, consequently, the decline of motivation, aspiration and interest occurs. By the time the child reaches young adult status, he is ill prepared to meet the demands of even the most menial job.

"It's a syndrome that never gets better particularly in our inner cities. But unfortunately now, that syndrome has grown even in the suburbs and farm communities of our nation."

Mr. Ford expresses an optimistic note about changes in education today:

"There are, however, faint glimmers of hope across the nation. In fact, school people today are looking to more creative solutions right here in Michigan. The Elementary and Secondary Education Act (1965) coupled with Economic Opportunity funds have made it possible for the educators to try new ideas, new theories to reverse the cycle, the syndrome of under achievement. Much attention is being focused in Michigan on the development of positive attitudes in teachers and pupils regarding their mutual relationship and the larger world of human development and understanding. Supplemental reading programs, counseling sessions in elementary schools hold some hope of breaking the cycle.

"But much more needs to be done. For example, we still direct 90% of the curriculum to 15% of the youth. The college-bound youth are in a minority, but vocational education is still a nasty word.

"Michigan schools must become the pre-apprentice workshops of our cities. They must begin to prepare skilled and semi-skilled craftsmen for the changing labor market. In this area, unfortunately, too little is being done to encourage those with skills and talents who want to work with their hands and their heads to pursue a realistic job-oriented trade.

Job Opportunities

"The most persistent problem in careers for the young people in Michigan cities is the problem of discrimination."

Mr. Ford says the federal civil rights Act of 1964 "was a heluful, yet devastating tool in the minority's quest of job opportunities. Today, discrimination has gone underground with culturally oriented qualifying entrance exams and education requirements — neither of which reflects the nature or complexity of the job to be performed."

The need in Michigan for skill training and manpower development is emphasized by MEOO Director Ford. He makes these observations:

"Michigan is the nation's leader in skill training and manpower development, but the barriers to open hiring and promotion by merit are still there. It is devastating to an individual to be trained for a career in machine operation only to find that the hiring restrictions exclude him because he's too heavy or too light in weight, because he only completed 11 years and 6 months of formal education or because his personality inventory indicated that he has hidden hostilities that don't fit into the pattern of a happy machine operator in our society. Or maybe he can't read well enough to put wheels on a new automobile at $4.75 per hour.

"Business, industry and government must begin to realize that the tax consumers in our soceity are capable of becoming tax producers if they are given a fair and equal opportunity. I believe no one — I repeat — no one really wants to be poor or unemployed. But those who are unemployed and poor are lost in a world of change in which they've never participated from the very beginning.

"A survey completed in Detroit in 1966 reported that trainees in a 1963 manpower program had already repaid in new tax revenues the money invested in their training. And that report did not include reduced welfare costs, subsidized housing or, more importantly, restored dignity and independence."

Mr. Ford, in discussing employment, declares that, "Much remains to be done. There are still nearly as many available jobs as there are unemployed people. Something creative must be done to bring the jobs and people together! Michigan State Department Civil Service has just now embarked on a campaign to hire the hard-core unemployed in aide positions in departments throughout the state. We must support and augment that program. Business and industry need a tax incentive to hire and train new employees. Or at least the extension of the current On-the-Job Training re-imbursement to open new jobs and new careers to poor people."

Recreation

Mr. Ford sees recreation as another key along with education and employment in the solution of the problems. He reports that "we anticipate summer programs soon in nearly every urban area in this state financed by OEO with 20% matching from the local community. Local organizations, agencies, government and especially the Michigan Youth Commission can assist in helping to form guidelines, new ideas, and new techniques. These experiences can help many individuals learn and grow in their understanding of the ghetto, the slum, the whole culture of poverty."

Local Involvement

The importance of local involvement in the study of and solution of the complex problems is stressed by Mr. Ford.

"Many lay organizations today are discussing and studying many topics that no one could discuss five years ago," he reports. He asks pointedly: "Was anyone talking about the participation of young people or for that matter participation of all consumers of service, the poor, the minority in the decision making process before 1964?"

Mr. Ford expresses his belief that "Community Action Programs or for that matter all OEO programs are not and will not be the panacea for poverty in our nation. Locally and nationally, OEO funds make up less than 1 - 2% of the monies being directed at socio-economic and human development.

"The 50 million dollars spent in OEO monies in Michigan is far short and almost insignificant in comparison to the 4.9 billion dollars of all federal monies being used in this state."

The needs for local citizens to participate voluntarily in action programs to provide better job opportunities, educational programs, and community-based neighborhood improvement projects are stressed by Mr. Ford.

Mr. Ford presents this challenge to Michigan residents:

"Involvement is a great concept, but it must mean the involvement in significant decision making of those who are victims of 'The System.' Only through courage, creativity, total involvement of youth and adults, and a lot of hard work can we serve as part of the alternative to 'The Fire Next Time.' "

* * *

(This article was developed by Managing Editor Herbert A. Auer from an address given by Mr. Ford to the Michigan Youth Commission. Several MD members of the Youth Commission suggested that all physicians would be interested.)

MANY MSMS COMMITTEES, GROUPS HOLD MEETINGS

Thursday, December 7
Regional Leadership Conference
Park Place Hotel, Traverse City

Friday, December 8
Committee on Mental Health
Statler-Hilton Hotel, Detroit
Chairman: Benjamin Jeffries, M.D., Detroit

Monday, December 11
Regional Leadership Conference
Mr. President Motor Inn, Grand Rapids

Tuesday, December 12
Advisory Committee to Executive Director
MSMS Headquarters
Chairman: Robert J. Mason, M.D., Birmingham

Wednesday, December 13
The Council
MSMS Headquarters
Chairman: Robert J. Mason, M.D., Birmingham
County Societies Committee
MSMS Headquarters
Chairman: John J. Coury, M.D., Port Huron
Finance Committee
MSMS Headquarters
Chairman: Robert K. Whiteley, M.D., Detroit
Publication Committee
MSMS Headquarters
Chairman: Brooker L. Masters, M.D., Fremont
Committee on Eye Care
MSMS Headquarters
Chairman: Robert T. Blackhurst, M.D., Midland

Thursday, December 14
Committee on Legal Affairs
MSMS Headquarters
Chairman: Otto K. Engelke, M.D., Ann Arbor

Monday, December 18
Regional Leadership Conference
Kingsley Inn, Bloomfield Hills

Wednesday, December 20
Liaison Committee with Michigan Chapter of Health Insurance Council
Sheraton-Cadillac Hotel, Detroit
Chairman: John J. Coury, M.D., Port Huron

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timed-release tablet contains:

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Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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clip and file under "flu"

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Tussagesic timed-release tablets

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Representative

New Certificates Ask More Info from Doctors About Births, Deaths

Considerable discussion among Michigan doctors continues regarding the new certificates which became effective January 1 for live births, deaths, and fetal deaths.

Michigan physicians and those across the nation were required to use the U.S. Public Health Service revised standard forms on January 1.

The Public Health Service contends that the 1956 revision of the certificates did not ask for adequate socioeconomic information on birth certificates.

Governmental officials also point out that, "with present emphasis on comprehensive health planning based on factual data, the need for state-to-state comparisons of uniform vital statistics becomes essential."

Physicians are facing questions on the certificates that they are not readily able to answer.

Most of the new items on the forms appear in a special "Confidential" section. These items will not appear on certified copies of the records. The confidential section is part of the birth and fetal death certificates.

The section on race in the birth and fetal death certificates appears in the confidential section.

Following is a brief listing of the new items on the three forms. The reasons why the new information is sought are paraphrased from an explanatory Michigan Department of Public Health bulletin:

A) **Birth Certificate.** (To be recorded)

1. The hour of birth. This will be helpful as legal evidence, to document the order of delivery in the case of multiple births, and it may be useful in perinatal studies.
2. The relationship of the informant to the child. This will provide a source of contact for additional information or the correction of errors.
3. The education of both parents. This item replaces sections on occupation and kind of industry. It is regarded as a more stable and specific socioeconomic measure.
4. Date of last live birth and date of last fetal death. This information is used to measure child spacing.
5. Date of last normal menses. This replaces the length of pregnancy section.
6. Month of pregnancy prenatal care began. This information will be helpful in programs to reduce fetal and infant mortality.
7. Prenatal visits. This information will complement the section on the beginning of prenatal care.
8. Complications not related to pregnancy.

B) **Fetal Death Certificate.** The same *new* items listed under *birth certificates* are also on this certificate. In addition, there is to be recorded:

1. Cause of fetal death: specify fetal or maternal. This helps establish underlying cause of death and is useful on the pathology of fetal death.
2. Autopsy: if Yes, were findings considered in determining cause of death? This helps provide evidence of the reliability of cause-of-death certification.

C) **Standard Death Certificate.** What follows are new items to be recorded on the death certificate:

1. Surviving spouse. This information is useful in cases of inheritance, social security claims, and veterans benefits.
2. Autopsy: if Yes, were findings considered in determining cause of death?
3. Certification. Physician is asked to indicate whether or not he saw the body after death and to certify place of death, dates of attendance, date last seen alive, date of death, and cause (s).
4. Cause of Death. "Or as a consequence of" has been added to allow the physician to enter a cause from an underlying time sequence which leads to death, but is not considered strictly cause-effect. For example, terminal pneumonia following a stroke might be considered a "consequence of" rather than "due to" stroke.

To fight TB-
find it first!

Make tuberculin testing routine with every physical examination.

TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

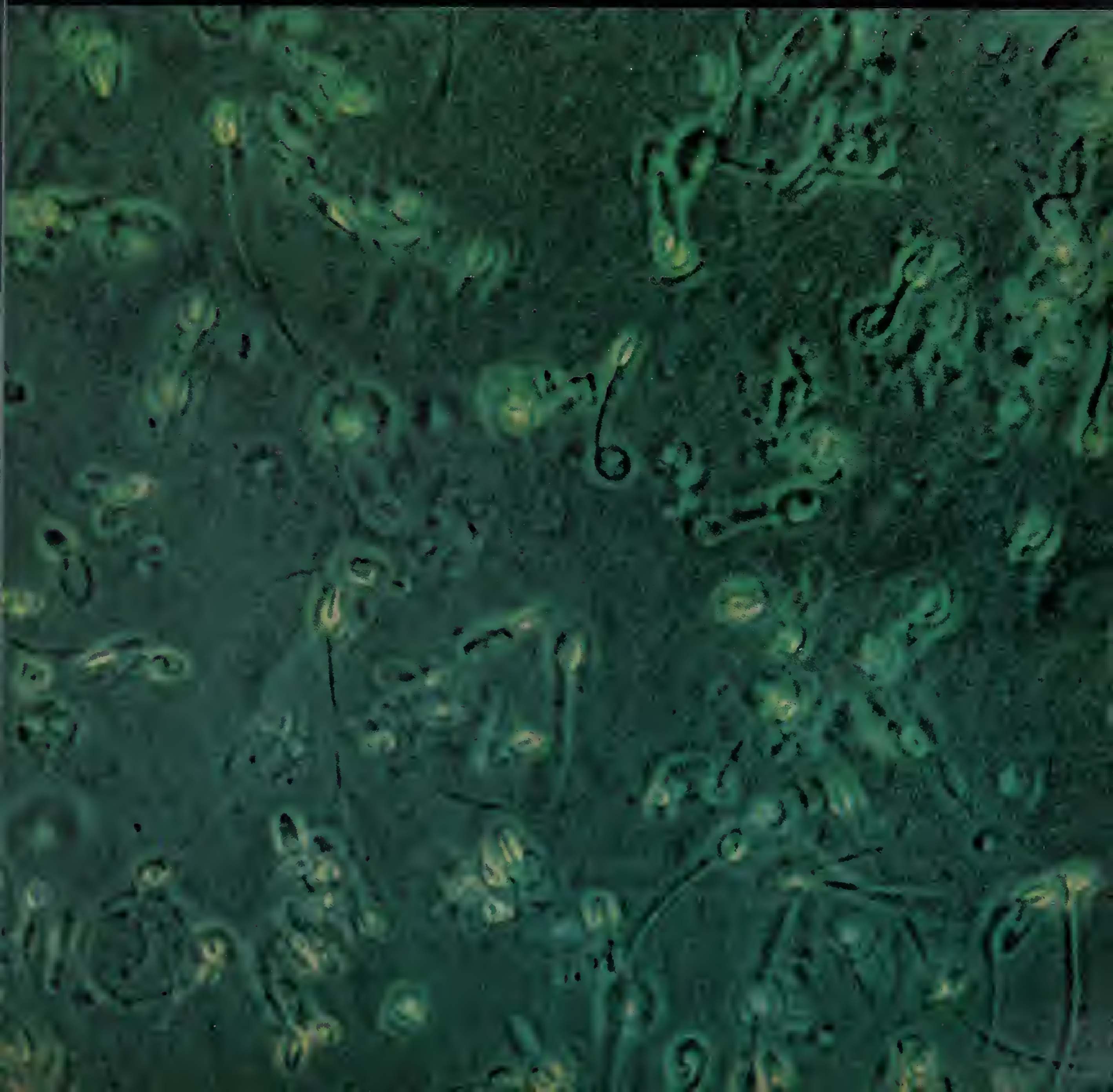
Lederle

330–8/6135

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

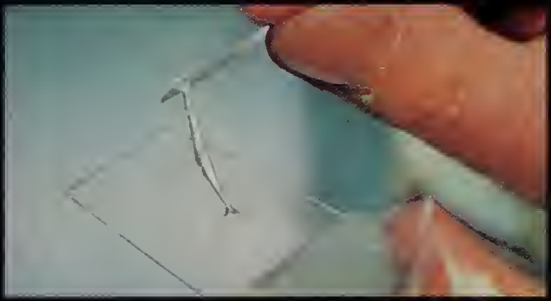
SYNTEX

LABORATORIES INC., PALO ALTO, CALIF

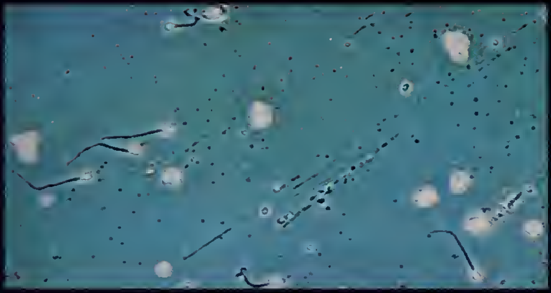
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

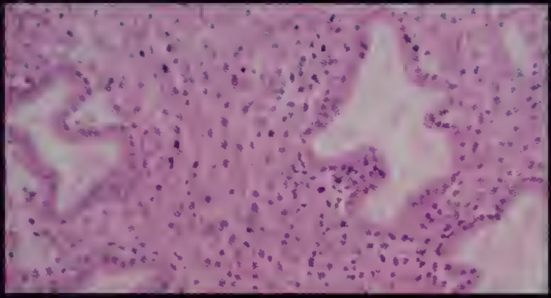
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

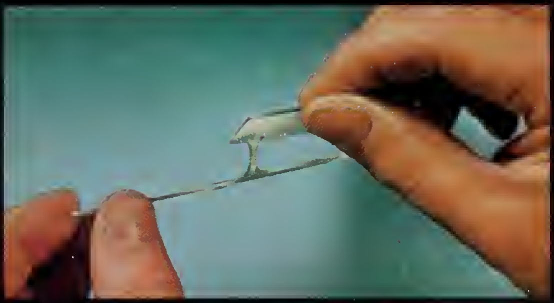


Spermatozoa appear healthy, active, freemoving.

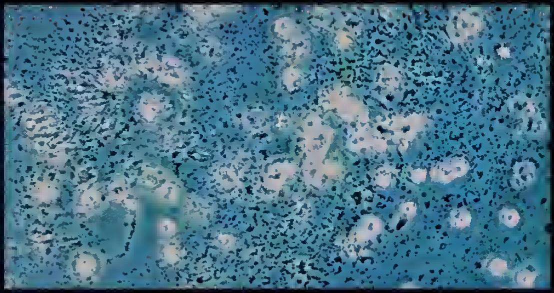


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

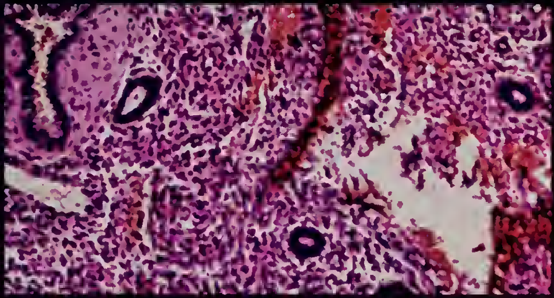
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-l.



Norethindrone in Norinyl-l accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

- new low dose of time-proved ingredients
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- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

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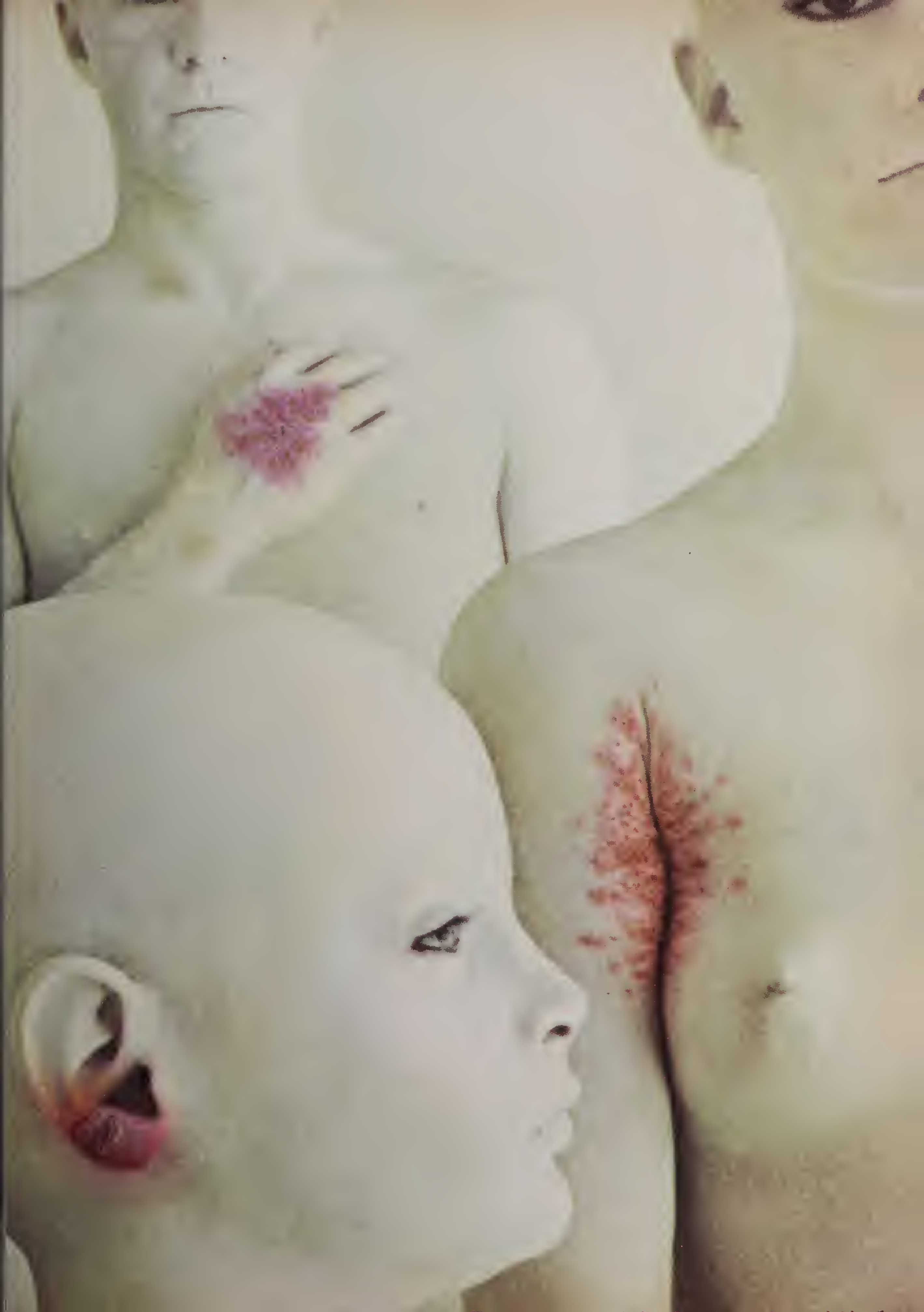
The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide



For everyday topical steroid therapy
Synalar® 0.01%
fluocinolone acetonide
provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from

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SOLUTION
SYNTEX
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SYNALAR®
[FLUOCINOLONE ACETONIDE]
CREAM
SYNTEX
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Palo Alto, Calif
CAUTION
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Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming),
Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

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Annual Conference for Michigan Health Planning Set for Detroit, Feb. 22-23-24

Every MSMS member is invited to participate in the First Annual Conference for "Michigan Health Planning and Related Subjects," in Detroit, February 22-23-24.

The conference will be sponsored by MSMS in cooperation with other statewide health associations and agencies in Michigan.

The program for Thursday, February 22 will focus on "The Doctors, Law and the Courts."

The emphasis Friday, February 23 will be on "Health Planning and Its Affect on Physicians, Hospitals and Communities."

The Annual MSMS Conference for Component Society Leaders will be held on Saturday, February 24.

Detailed programs and registration forms are being mailed to every MSMS member, and to many special invitees.

"Some members will be able to attend all three days — but if you cannot, please pick out the day or days that interest you the most and come for those," points out President Harris. A nominal registration fee will be charged for February 22 and 23 to help defray the expenses.

Thursday, February 22

The program for Thursday, February 22 at the New Center Motor Lodge will feature top-flight attorneys, judges, legislative representatives and physicians. The subjects, listed on the inside back cover of this issue of *Michigan Medicine,* will deal with such vital everyday subjects as malpractice, privileged communications, the doctor in the courtroom, revision of the Michigan criminal code, revision of the Michigan medical practice act, and new legislation in Washington and Lansing.

Friday, February 23

The timely topics for Friday, February 23, also at the New Center Motor Lodge, will provide doctors with insights into the recent recommendations of the National Advisory Commission on Health Manpower, and the developments in Michigan to implement the Comprehensive Health Planning Law (PL 89-749) and the Heart, Cancer, Stroke Law (PL 89-239) and the implications of all three to private practice. The program also will discuss "The Voluntary Approach to Health Planning."

Component Societies Conference

Saturday, February 24 will be the annual MSMS Conference for Component Society Leaders at the Wayne County Medical Society Headquarters. The officers and the legislative and public relations chairmen have been invited to an informational program that will provide workshops and also opportunities to discuss legislation, politics, ethics and professional conduct, public relations, and quackery education.

Some Speakers Listed; Others Coming Too

THURSDAY, FEBRUARY 22

"THE DOCTORS, LAW AND THE COURTS"

—D. F. Doehrman, General Manager, Medical Protective Company, Fort Wayne, Indiana

—Judge Horace E. Gilmore, LL.B., Wayne County Circuit Court

—Jerold H. Israel, Professor, University of Michigan Law School

—Joseph B. Bilitzke, LL.B., Lansing, Assistant State Attorney General

—Bernard D. Hirsh, LL.B., Director, AMA Law Department

—Ernest B. Howard, M.D., Assistant Executive Vice-President of the AMA

FRIDAY, FEBRUARY 23

"HEALTH PLANNING AND ITS AFFECT ON THE PHYSICIAN, HOSPITAL AND COMMUNITY"

—Harold Margulies, M.D., Washington, D. C., one of the key men in the National Advisory Commission on Health Manpower and its Report.

—Michigan Lieutenant Governor William B. Milliken

—Dean William N. Hubbard, Jr., M.D., President, Michigan Association for Regional Medical Plans

—George W. Slagle, M.D., Battle Creek, Chairman, AMA Council on Medical Service

SATURDAY, FEBRUARY 24

"MSMS CONFERENCE FOR COMPONENT SOCIETY LEADERS"

—The Honorable Frank J. Kelley, LL.B., Michigan Attorney General

—Doyl Taylor, LL.B., Director, AMA Department of Investigation

—C. Darrell Coover, AMA Washington Office

—MSMS Officers, and others

COME TO FEBRUARY CONFERENCES

The Best We Can —Is Better Together

Today's doctor is expected to be a paragon of virtue, a superb administrator, a community leader, an unparalleled healer, the captain of the health team and a health authority; not to mention such additional qualities as being a family man, a pillar of the church, an active participant in medical society affairs, and it helps if he keeps in athletic trim by participation in golfing skiing, etc.

SIMILARLY, THE STATE AND county medical societies are expected to be authoritative sources for all scientific medical advancements, participants in all governmental health planning, experts in legislation of practically all varieties, highly influential in political matters, economic sages in health-hospital-medical insurances. They must publish scientific journals, arrange and sponsor post graduate education, filter all pharmaceutical and technical proposals and advertising, and act as father confessor to all members of the profession at the same time shielding them from the more gauche varieties of public wrath resulting from inevitable professional indiscretions.

Knowing the limitations of both human and organizational conduct, no reasonable man could expect the doctor or his organization to be 100 percent successful in living up to the expectations listed above. The answer is that *we do the best we can.*

On the other hand, it has been demonstrated repeatedly over the years that we do the best we can *better* if we act together as a profession and through our country and state medical societies.

BY PRESENTING A UNITED front, we make fewer mistakes, our services are more altruistically motivated and we maintain standards that are of advantage both to our patients and ourselves.

In the scientific medical field, we are glad to share responsibility between our medical society, our hospital staffs and our specialty groups. But in the field of health planning (categorical or comprehensive), and particularly in respect to its legal-sociological-political-economic elements, the medical societies must be primary. The fact that these elements are now playing a part equal to that of scientific medicine in the "warp and woof" of the average doctor's practice is no longer subject to argument; and the changes in these non-scientific matters are coming as rapidly as the changes in scientific medicine.

It was with all of the above thinking in mind that a new meeting for the total membership has been developed. Its sessions begin at 9:30 a.m. on Thursday, February 22, will continue through the 23rd with the third day being an annual county medical society officers conference.

THIS MEETING, which will be held at the Howard Johnson's New Center Motor Hotel in Detroit (near Fisher Building) will do one thing if nothing else: It will assist the person attending it solve some of the legal-sociological-political-economic questions which beset him in his daily practice. In doing so it will profit him as well as his patients.

We think at least one doctor from every medical office in the state should attend. Many non-doctors whose daily work directly affects the practice of medicine will also be present to hear and discuss the most recent proposals, with state and national authorities. This new meeting is recognition by the MSMS that neither the doctor nor his organization is quite able to do everything perfectly, but that as they do the best they can — *they can do it better together.*

100 YEARS OLD!

The Kalamazoo Academy of Medicine began its second century of service in January. It was on January 8, 1868 that six physicians began the "Kalamazoo Medical Association." Seven years later the name was changed to Academy.

Judicial Group Reaffirms Stand Re Rx Blanks

The MSMS Judicial Commission, at a recent meeting, studied and reaffirmed the position that, "It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon," reports Donald J. Sweeny, Jr., M.D., Chairman of the Commission.

The statement was a reaffirmation of a 1964 opinion of the Judicial Council of the AMA.

The Michigan State Pharmaceutical Association has been asked to inform pharmacists of this viewpoint.

Did You See Article About Seat Belt Injuries, Page 171?

Have you read the extensive article in the February issue of *Michigan Medicine* about "Lap Seat Belt Injuries: The Treatment of the Fortunate Survivor"?

The authors agree with the AMA Committee on Medical Aspects of Automotive Safety favoring the shoulder-lap system. In April, 1967, the AMA Committee urged the Engineering Advisory Committee of the Automobile Manufacturers Association for an overall seat design development to include a lap belt, upper torso restraint and adequate head protection.

Did You Save January Extra About Legislation?

Every member has been urged to keep in a handy place the January News Extra issue of *Michigan Medicine* because it was designed as a Special 1968 Legislative Supplement.

Important stories — for future reference — dealt with the status and location of the bills of primary concern to MSMS, with the membership of key House and Senate committees, etc.

Stewart Coming For SAMA Conclave

Principal speaker at the SAMA Awards Banquet on Thursday, April 25, in Detroit will be William Stewart, M.D., U.S. Surgeon General.

The Awards Banquet is part of the program of the 1968 national convention of the Student American Medical Association which will be held in Detroit, April 23-27. The WSU SAMA unit is serving as hosts.

Further details on speakers and topics will be carried in *Michigan Medicine.*

New Abortion Laws, Topic for Maternal Meet

One of the speakers at the Maternal Welfare Conference in Flint, March 26 and 27, who will shed some light on the controversial question of changing state abortion laws is E. Stewart Taylor, M.D., Professor and Chairman of the Department of Obstetrics-Gynecology, University of Colorado Medical Center, Denver. Colorado has recently liberalized its abortion laws.

Doctor Taylor is a former Flint resident, having taken his internship at Hurley Hospital in 1936-37, after receiving his M.D. degree at the State University of Iowa. He is the author of many scientific papers and several manuals in the field of obstetrics-gynecology.

STANDER

TAYLOR

Doctor Taylor will speak at 3:00 p.m., Tuesday, March 26, on "New Abortion Laws."

Another prominent authority in obstetrics-gynecology who will be speaking at the conference is Richard W. Stander, M.D., Professor and Chairman of the Department of Obstetrics-Gynecology, University of Cincinnati College of Medicine. Doctor Stander was born in Grand Rapids. He was graduated cum laude from the University of Michigan Medical School in 1951, where he also took his internship and residency; later becoming an instructor at U-M Medical School.

Doctor Stander will discuss "Intrauterine Pressures" at 1:30 p.m., March 26.

This year the Maternal and Perinatal Welfare Conference is being held on Tuesday and Wednesday, March 26-27 at the Pick-Durant Hotel in Flint. There is no registration fee and both physicians and the public are invited. A complete program can be obtained from MSMS headquarters, P.O. Box 152, East Lansing.

Smoking-Health Efforts to Focus On Grade School

Several educational programs for 1968 are being developed and launched by the Michigan Council on Smoking and Health.

The Council, at its recent annual meeting, also reviewed 1967 activities and elected officers.

George Pickett, M.D., Detroit, was elevated from vice-chairman to chairman to replace Elizabeth Wheeler, Dr. P.H., Mt. Pleasant. Herbert A. Auer, of the MSMS executive staff, was elected as the new vice-chairman and J. A. Doherty, executive director of the Michigan Health Council, was renamed secretary-treasurer.

MSMS and the seven other supporting Council agencies participated in the annual meeting.

The major Council activity this past year, with the help of physicians in many communities, was a state-wide educational program with the Michigan Congress of Parents and Teachers. Leadership training conferences this past year will lead to local programs and local projects in the neighborhood PTA's.

This coming year the Council will relate to physicians, youth, parents and teachers in various educational programs. Major emphasis will be placed on students in the elementary grades.

U-M HELPS MALAYSIA

Under a $292,000 Ford Foundation grant, the Center for Population Planning and the Population Studies Center at the University of Michigan will assist the Family Planning Board of Malaysia. The U-M will provide consultants and specialists, train Malaysian staff members in the U.S., cover the cost of a population survey analysis, and provide books and equipment for population studies.

Mumps Vaccine Advice Given

The federal government has licensed a live, attenuated mumps virus vaccine especially recommended for adolescent and male adults who can become sterile from the relatively innocuous childhood disease.

The vaccine, developed over a five-year period by the Merck, Sharp and Dohme Research Laboratories, was not recommended for routine use in infants and young children pending development of more information in the duration of the immunity it provides.

William H. Stewart, M.D., U.S. Surgeon General, said excellent protection against naturally occurring mumps has been observed for the first year after the single-infection live vaccine.

"But limited data on natural exposure during the second year indicate continuing protection although additional observation will be required to determine the duration of immunity protection," he said.

* * *

The U.S. Public Health Service Advisory Committee on Immunization has issued recommendations which have been relayed to county health departments by the Division of Epidemiology of the Michigan Department of Public Health. The U.S. recommendations, in part, state:

"Live mumps vaccine may be considered for use in children approaching puberty, in adolescents, and in adults, especially males, if they have not had mumps. The single individual dose recommended by the manufacturer should be employed. The vaccine is not specifically contraindicated for younger children, but the vaccine is not recommended for routine use."

The American Academy of Pediatrics Committee on Control of Infectious Disease also has issued an official statement. In part, the AAP declares: "Until more definitive information is available with respect to duration of immunity, the AAP Committee does not recommend the routine use of mumps vaccine for all infants and children." The AAP Committee recommends the vaccine for the following "if they have not had clinical mumps: boys who are approaching puberty; adolescent and male adults; and children living in closed institutions, perhaps in summer camps or under other similar epidemiological circumstances."

Two State Colleges Hear AMA Lecturer

An AMA lecture on clinical nutrition by Professor Edgar Gordon, M.D., will be given at Western Michigan University in Kalamazoo, February 6 at 8 p.m.; and at Northern Michigan University in Marquette at 8:15 p.m., Wednesday, April 3.

This past fall, Doctor Gordon gave lectures in nutrition at Hope College, Central Michigan University, and Ferris State College. He is presently professor of medicine and chief of the metabolism and endocrinology clinic at the University of Wisconsin Medical School.

Add: In Memoriam

In addition to the names reported in the January "In Memoriam" the following news has reached the MSMS office. Details will follow in the February issue of *Michigan Medicine*:

Harold D. Dykhuizen, M.D., 59, Muskegon, died November 25.

Donald F. Kudner, M.D., 71, Jackson, died December 13.

Elmer L. Whitney, M.D., 81, Detroit, died December 29.

NEEL LEADS EXPEDITION

A University of Michigan medical team has recently departed for the jungles of Venezuela to study the Yanomama Indians, primitive tribesmen still living in a Stone Age culture. Headed by James V. Neel, M.D., chairman of human genetics at U-M Medical School, the team will spend two months making medical, anthropological, and genetic studies of the Indians.

NIH Director Will Keynote WSU Symposium

James A. Shannon, M.D., Director of the National Institutes of Health, will deliver the opening address at Wayne State University's Centennial Symposium on "Extending the Life Span: The Impact on Man" in Detroit, February 15 and 16. The banquet address will be made by Wayne State University President William R. Keast.

The two-day program will be devoted to exploring the implications of increased longevity for medicine, society, and the dignity of many in the urban setting. All sessions will be held at the McGregor Memorial Conference Center on the WSU campus.

Speakers also will include: William D. Bechill, Commissioner, Administration on Aging, Department of Health, Education and Welfare; Solomon Axelrod, M.D., School of Public Health, University of Michigan; Justice Theodore Souris, Michigan Supreme Court; Robert N. Butler, M.D., research psychiatrist at Washington University School of Medicine, and Walter M. Beattie, Jr., dean, School of Social Work, Syracuse University.

A complete program can be obtained from WSU Symposia Office, 5229 Cass, Detroit 48202, TE 3-1400.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
ENDURON®
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na$^+$ output, yet easy on the K$^+$

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension

DESERPIDINE
METHYCLOT ZIDE
100 No. 6838
Tablets (Grooved)
ENDURONYL®
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

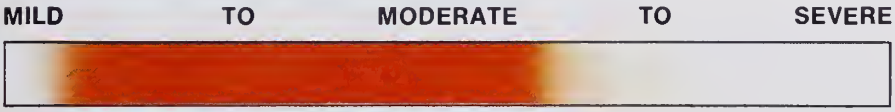
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

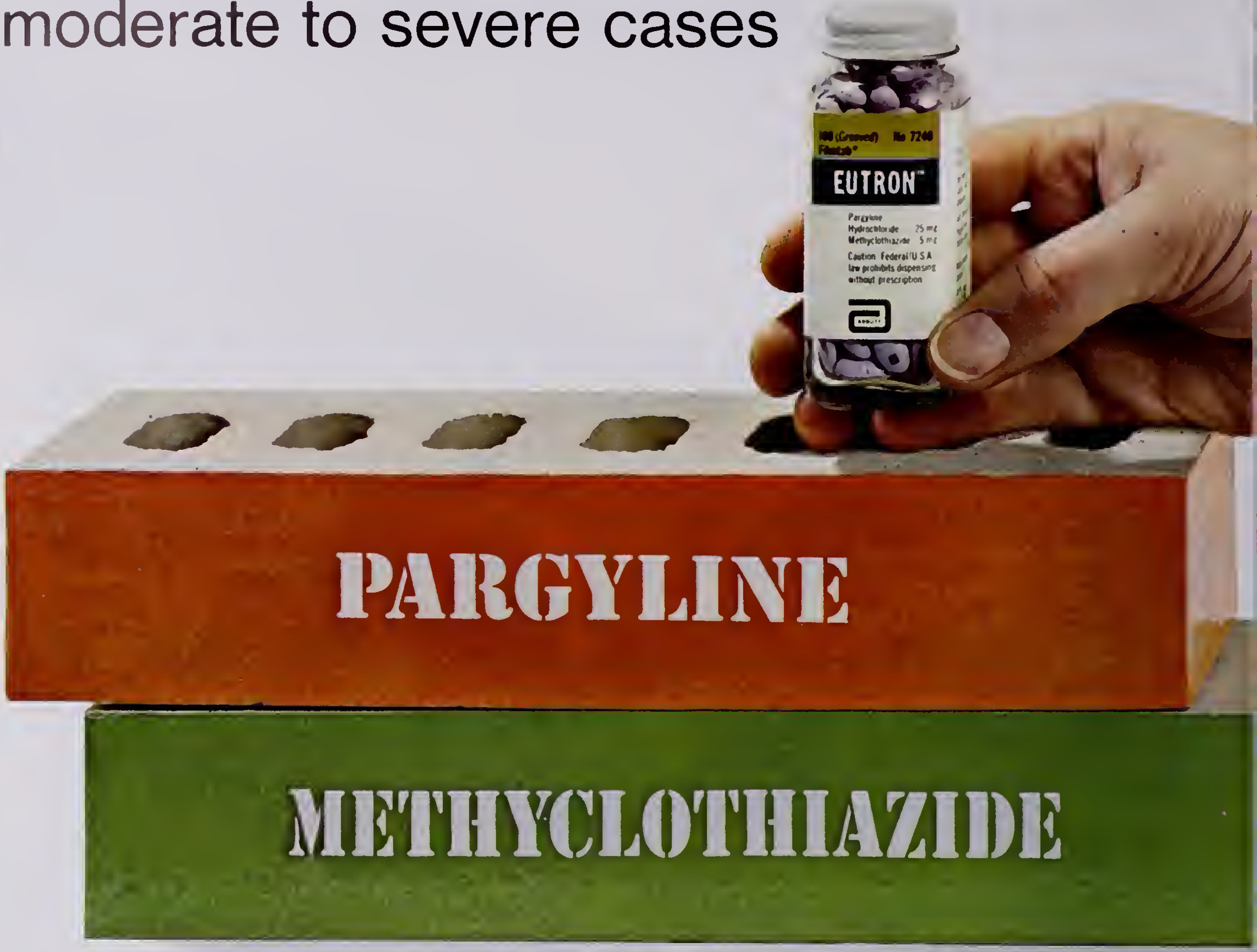
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal/U.S.A. law prohibits dispensing without prescription
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METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-TRADEMARK

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination. 801438

ABBOTT

Reactions Sought to Suggestions of The National Advisory Commission On Health Manpower

MSMS members have several opportunities to express their reactions to the recommendations of the National Advisory Commission on Health Manpower.

Views of MSMS members can be routed through the MSMS delegates to the AMA and through the MSMS Committee on Governmental Medical Care Programs and MSMS Education Liaison Committee to The MSMS Council and thus to the AMA.

Opinions also are invited by the MSMS Publication Committee for use in *Michigan Medicine*. "Our journal serves as a sounding board for our members and letters are invited for the monthly 'Mailbag' feature," explains Brooker L. Masters, M.D., Fremont, Chairman of the Publication Committee.

The Michigan delegates to the AMA Convention and the others at Houston approved the report from the AMA Board of Trustees re the National Advisory Commission on Health Manpower Report.

THE AMA BOARD OBSERVATIONS, in part, declared "The 'Report of the National Advisory Commission on Health Manpower' reflects much of the serious attention given to the evolving needs of health care long recognized, studied and implemented by the American Medical Association and other professional groups in the health fields.

"The Report will receive the intensive study of the various expert groups within AMA and reports on their recommendations will be issued as soon as they can be developed properly. There appear to be some areas in which modifications will be necessary to assure attaining objectives sought for advancement of health care for all citizens."

The 15-member Commission, in its report to President Johnson, commented on many aspects of medical school, foreign doctors, financing of medical education, paramedical personnel, etc.

The Commission, headed by J. Irwin Miller, chairman of the Cummins Engine Co., Columbus, Indiana, was set up in May, 1966, by President Johnson to recommend ways to meet health manpower needs. Five physicians signed the report, including Dwight Wilbur, M.D., AMA President-Elect.

THE COMMISSION MEMBERS agreed that tackling the problem of manpower, alone, would not cure present ills.

". . . If additional personnel are employed in the present manner and within the present patterns and systems of care, they will not avert, or even perhaps alleviate, the crisis," the Commission said.

"Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in costs and in numbers of health personnel."

The AMA Board of Trustees, in its report to the Houston Convention, in part said, "The Commission appears to recognize the needs arising from the rapid growth of the public's desire for health care. This attitude is the result of increasing awareness of the great advances in medical science and techniques, and of the prolongation of life for millions into middle and advanced ages. . . ."

THE FEDERAL COMMISSION seems to direct some of its proposals at the AMA, MSMS and other medical organizations. Three of the proposals made by the Commission suggested:

". . . Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals.

". . . Professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

". . . Professional societies, universities, and state governments should undertake, with federal support, studies on the development of guidelines for state licensure codes for health personnel."

Several of these suggestions were considered recently during the discussions at the three MSMS regional leadership conferences at Traverse City, Grand Rapids, and Birmingham.

SEVERAL OF THE recommendations under study by the AMA, the MSMS Education Liaison Committee and others deal with medical students. The Commission report states:

". . . The federal government should make available to any medical student loans to cover the full costs of tuition and living expenses during formal professional education. The student should be able to choose between repaying the loan from earnings over a period of years or giving two years of his time to approved national service apart from Selective Service obligations.

". . . The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates."

The Commission Report offers several proposals related to medical schools:

". . . Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality.

". . . The federal government should give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals."

AMONG THE OTHER Commission proposals of special interest to MSMS and its component medical societies are these:

". . . At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools.

". . . Programs for health care of the disadvantaged should be given highest priority and made available wherever needed.

". . . Nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions."

The views of AMA bodies will appear in future reports as it compares the Commission's suggestions against the AMA efforts to provide high quality care to all Americans.

OAKLAND PROMOTES USE OF FILMS BY LAY GROUPS

Oakland County Medical Society continues its tradition of cooperation with the Oakland County Health Department with a donation to help the department purchase the film, "A Quarter of a Million Teenagers." This is the third film which OCMS has helped purchase for the health department.

OCMS has also recently purchased the film "Parent to Child About Sex," produced by Frederick Margolis, M.D., of Kalamazoo. The film will be available from the medical society to all interested groups on a rental basis. The society plans to establish a film library.

NEW CHAIRMEN LEADING 15 MSMS COMMITTEES

The pace of MSMS committee work is picking up these winter months. Fifteen of the committees this year have new chairmen and they face organizational jobs to move their committee study and projects ahead.

Following is the list of new MSMS committee chairmen.

County Societies — J. J. Coury, M.D., Port Huron.

Education Liaison — Milton R. Weed, M.D., Grosse Pte. Park.

Liaison with Michigan Chapter of Health Insurance Council — J. J. Coury, M.D., Port Huron.

Liaison with Michigan State Pharmaceutical Association — H. C. Hansen, M.D., Battle Creek.

Liaison with Podiatry — Wm. H. Blodgett, M.D., Detroit.

Liaison with State Bar of Michigan — O. J. Johnson, M.D., Bay City.

Alcohol and Drug Dependence — H. A. Raskin, M.D., Detroit.

Awards — C. Allen Payne, M.D., Grand Rapids.

Beaumont Memorial — B. M. Harris, M.D., Ypsilanti.

Hospital Relations — J. J. Coury, M.D., Port Huron.

Advisory of Past Officers — C. Allen Payne, M.D., Grand Rapids.

Advisory to Woman's Auxiliary — E. H. Rodda, M.D., Bay City.

Maternal Health — J. E. Harryman, M.D., Muskegon.

Scientific Radio & Television — Wm. J. Ledger, M.D., Ann Arbor.

Veneral Disease Control — F. B. Bicknell, M.D., Detroit.

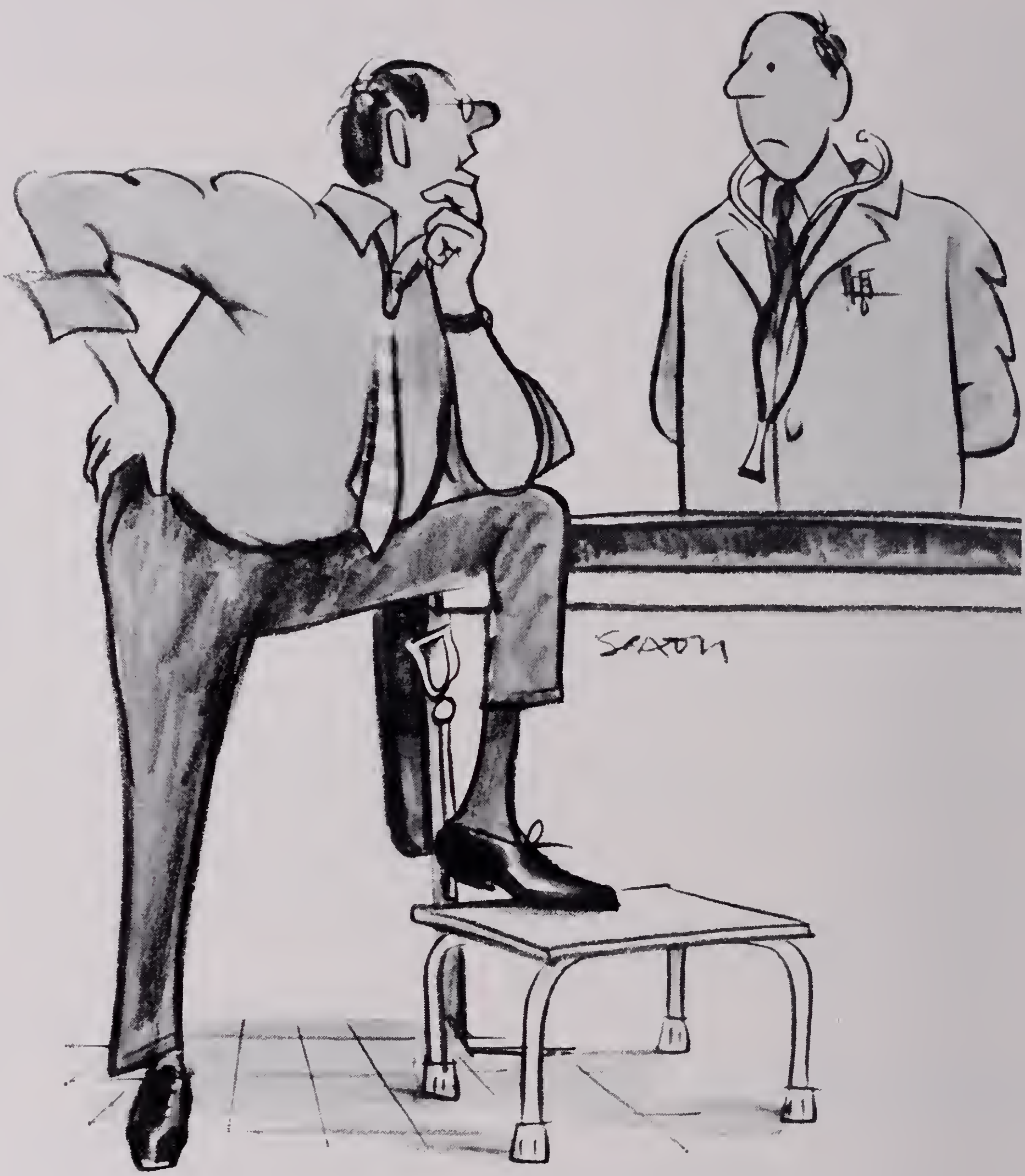
The MSMS House of Delegates committees have not been appointed to date and likely will include some other MSMS members in new positions as committee chairmen.

Pleads for Unified Voice

"The necessity for a clear and unified voice with which medicine can speak to both the public and to legislators is so clear that it needs little or no further documentation by me.

"We are in an era of medical legislation, as more and more credence is inclined to be given by many persons to the theory that health care is something to be provided by the government — just as interstate highways are built and mail is delivered by the government."

—Milford O. House, M.D.
AMA President



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

NOVAHISTINE LP
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DOW **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

Extract of Council Minutes, Dec. 13

The Council received a report from the Michigan Delegation to the American Medical Association, Luther R. Leader, M.D., Chairman, who reviewed the action of the AMA House and the involvement of the MSMS Delegates.

Further information regarding the Treasurer's recommendations for revision of the MSMS financial management policies was received from the Treasurer and The Council approved the Treasurer's recommendations. A special session of the House of Delegates was approved, to be called prior to March 9, 1968, in order to consider the Treasurer's report as recommended by The Council.

Resolutions referred to The Council by the 1967 House of Delegates were acted upon by The Council, these being referred to the appropriate committees for implementation.

An Ad Hoc Committee to study Blue Shield was authorized by The Council in July, and the following committee members were invited to serve as of this date: Kenneth H. Johnson, M.D., Chairman, Sidney Adler, M.D., James B. Blodgett, M.D., Harold F. Falls, M.D., John R. Pedden, M.D.

President Bradley M. Harris appointed Norbert W. Scholle, M.D., Muskegon, to the Judicial Commission, filling the vacancy on the Commission due to the resignation of Carl B. Beeman, M.D.

William H. Plesscher, M.D., Lansing, was appointed as MSMS representative to the new Michigan Abortion Review Council.

Secretary Johnson reported the results of the election of the Judicial Commission: Robert H. Hamburg, M.D., Detroit, District 1; Sherman E. Andrews, M.D., Kalamazoo, District 5; W. H. Huron, M.D., Iron Mountain, District 7.

The Finance Committee recommended adoption of a budget for the fiscal year 1967-68 and commended the MSMS staff for managing expenditures for the 1966-67 budget within 1% of the proposed budget.

The Council authorized a task force composed of chairman of MSMS scientific committees to develop a possible education program for doctors and the public regarding smoking and health.

The Council reviewed committee reports from the Committee on Professional Insurance Plans, the Committee on Mental Health, the Committee on Legal Affairs, the Committee on Maternal Health, the Committee on Alcoholism and Drug Addiction, the Committee on Postgraduate Medical Education.

Clarify Questions About Osteopaths as Associate Members

MSMS Council Chairman Robert J. Mason, M.D., has written an explanatory letter to component medical societies to clarify possible questions about the election of osteopaths to associate membership.

The 1967 MSMS House of Delegates at its recent meeting in Grand Rapids approved Resolution 39 which states that osteopathic physicians may be associate members of a component society. The resolution also encourages component medical societies to offer associate membership to local osteopathic physicians on an individual basis.

A number of county medical societies are considering osteopths, who practice scientific medicine, as possible associate members.

Doctor Mason reports that "the MSMS Legal Counsel" has advised that osteopaths are eligible for election to associate membership of a component society on an individual basis, providing that he or she qualifies under Chapter 2, Section 3 (a) of the MSMS Bylaws which says, 'Any person not a member of the medical profession but engaged in scientific or professional pursuits the principles and ethics of which are consonant with those of this Society.'

"Any osteopathic association member of a component society may become an associate member of MSMS upon recommendation of a component society and election by the House of Delegates, as was done in September, 1967."

Doctor Mason also has explained that "any osteopathic associate member shall not pay dues to MSMS and shall not have the right to vote or to hold office in MSMS or his component society. A component society may require an associate member to pay local dues out of which the $6.00 subscription fee shall be paid to the State Society for *Michigan Medicine*."

Recalling MSMS Years Of Effective Service . . .

Following are some quotations from various years of the impressive MSMS service record:

1941-42

"The MSMS Medical Preparedness Committee was active in encouraging the procurement of 800 medical officers. Approximately 200 Michigan doctors joined the armed forces in 1940-41."

1930-31

"The MSMS Cancer Commission held its first meeting and decided to make a survey of the facilities for the diagnosis and treatment of cancer in each county."

1959-60

"Work on the new MSMS headquarters in East Lansing continued during the early months of 1960 and the staff moved from 606 Townsend to 120 West Saginaw in April, 1960."

(The above quotations are from A Century of Service in Medicine, the excellent history of MSMS written by MSMS Historian Wm. J. Stapleton, Jr., M.D., for the MSMS Centennial. Copies of the book are still available at cost. Send a check for $2.00 to the Michigan State Medical Society, 120 West Saginaw, East Lansing 48823.)

MEOO DIRECTOR VOICES HIS VIEWS — SEE PAGE 214

Want to understand cities and poverty and stress better?

The article quoting the views of MEOO Director Wm. R. Ford, on Page 214, will help.

Many speakers in Michigan this year have called attention to the problems of cities. Some of the views of Mr. Ford were supported in Detroit when Richard Prindle, M.D., Assistant Surgeon General of HEW, spoke to a WSU Centennial symposium. In part, he said, "If we continue to produce cities — or maintain cities — in which tension and stress, insults to physical and mental health are common, people will explode again and again in riots and destruction.

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HEW Official Cites Many Problems Facing Sprawling Megalopolis

Our nation desperately needs community leaders, universities and others to bring the urban revolution under control.

So declared Philip R. Lee, MD, Assistant Secretary to Health and Scientific Affairs, US Department of Health, Education, and Welfare, in his address at a recent Wayne State University Centennial symposium.

In part, Mr. Lee declared:

"We must learn to mold megalopolis to our own ends and to society's ends—to restore and preserve the sense of community identity and responsibility without which no society can long endure."

"The national government," he said, "looks to the people to offer their own resources of imagination, effort and brains in a mutual effort to find the solutions which we know we must have."

THE NEW FREEDOMS of automobile, super highway, telephone, nuclear power, etc., he said present new problems. He described the immense and sprawling megalopolis as "not truly a city but an unstructured mass with no government, no official spokesman, no self-consciousness, no sense of total community."

Air pollution and waste disposal, he suggested, are two of the concerns that no city, county or state government can solve.

Doctor Lee told the WSU symposium that, "Surely we want and need healthy communities, but we have a great many sick ones. Of course, we wish our communities to be coherent, but they appear instead to be becoming diffuse, unstructured, and impersonal.

"We see its symptoms, some of which are obvious and painful. The decay of the central cities, the summer riots, crises in urban transportation, the flight to the suburbs, air and water pollution, poverty, crime and ill-health all offer evidence of major social upheaval.

"However, these are only symptoms; they are not the revolution itself. We cannot treat them piecemeal; we must first understand the great underlying forces of which they are the obvious products."

DOCTOR LEE EXPRESSED his opinion that, "we must be concerned more about human spirit than geography. Basic to the problems is the person's own consciousness of the community around him and the role he himself plays in that community.

The personal problems today, Doctor Lee says, include these:

"Does he know his neighbors?

"Does he know where to go when he is ill?

"Does he know on whom to rely when he is in trouble?

"Does he belong to a coherent social unit?

"Does he know that he is a necessary part of the community—in fact, does he take the trouble to vote?

"Will it surprise him if he is asked to help in a worthy community cause?"

SOME OF THE COMMENTS by Doctor Lee about the city today will especially interest the Detroit Metropolitan physicians.

In part, he said:

"We must concede that the American city today has gross defects.

"It does not fully employ our technical, scientific or economic capabilities.

"It does not exemplify our most highly honored civic ideals.

"It does not inspire the best that individual men and women can contribute to community life.

"It does not provide suitable environments for the full range of human activity for all sectors of our population.

"It does not have the means to insure its orderly growth and renewal.

"It does not possess resources adequate to cope with any long-sustained interruption of its energy supply, food or services."

IN HIS COMMENTS aimed at the universities, Doctor Lee declared, "It is a primary task of our great institutes of higher education to envision and help plan our cities of the future, to study them as they are now, and to discover the ways by which their defects can be corrected.

"Surely the university must change as it reacts to the times, but no change can reduce the university's value to the Nation as a whole, or the responsibility of the university to provide intellectual leadership."

"Almost Endless" List Of Factors Complicate Health Work in Cities

What factors affect the work of physicians to improve health care in the big cities?

James A. Lee, HEW official, in his recent address at a WSU Centennial symposium, cited some of the problems of the big cities. In part, he said:

"We lose more than 24 of every 1,000 infants born alive in the United States — a record far poorer than that of many countries far less affluent than ours. And infant mortality is twice as high for the non-white as for the white child.

"Chronic illness, including cancer and heart disease, is far from being conquered.

"We do far too little in the provision of family planning services for the estimated 5 million American women who need this assistance.

"By 1970, our population will be about 209 million — and yet we are far from capable of providing for our present population of some 200 million.

"Almost 34 million people are living in poverty today in the United States, many millions of them in big-city slums.

"More than 3 million substandard housing units are occupied by underprivileged American families.

"Only about 100 of the 3,000 counties in the United States have developed coordinated community planning for their older citizens.

"Many public institutions caring for juvenile delinquents are operating below standard because of obsolescence or overcrowding.

"Our big cities are being strangled by their own traffic, and we are far behind in the development of mass transit facilities.

"Pollution in rivers, lakes and other waterways is steadily increasing. Almost half of the United States population drinks water which does not meet even minimal standards of purity.

"This nation is so rich that it throws away countless tons of waste each year — and we are far from learning what to do with it. The result: gross pollution of the air, the water, and the land.

"The list is almost endless. When we add the problems of alcoholism, drug addiction, crime, bigotry, the revolt of youth, the limited education of the underprivileged, the shortage of medical and educational manpower, mental illness and mental retardation, the physical and emotional ailments which afflict so many of our children, it becomes painfully clear that we are facing no easy task."

Consumer Price Index Up Slightly for Detroit

The most recent statistics from the Bureau of Labor Statistics reveal a slight increase in the Detroit Consumer Price Index according to the current issue of the *MSU Economic Review* report of business conditions in Michigan. The Review continues:

"The Index stands at 115.5, up 2.6 percent from a year ago. Goods and services which could have been purchased for $10 in the period 1957-59, now cost $11.55.

"Health and recreation prices rose by 4.8 percent during 1966-67. Their percentage increase 1957-59 and since last year has been greater than any of the other major groupings making up the index for all items. Within the health and recreation group, the index for medical expenses is the highest, presently at 147.0 and showed an increase of 6.7 percent during last year.

"A recent press release from the Bureau of Labor Statistics said that although most food categories showed small advances in prices, cereals and bakery products increased 1.3 percent because of an increase in the cost of flour. Prices of fresh fruits and vegetables rose 0.8 percent from September to October."

CONSUMER PRICE INDEX FOR DETROIT

Group	October, 1967 (1957-59 = 100)	Percent change from Sept. 1967	Oct. 1966
All Items	115.5	+ 0.2	+ 2.6
Food	114.7	+ 0.2	+ 1.1
Housing	109.7	+ 0.2	+ 2.8
Apparel and Upkeep	114.7	+ 0.3	+ 2.0
Transportation	114.8	+ 0.5	+ 2.1
Health and Recreation	128.2	-0-	+ 4.8

Source: Bureau of Labor Statistics

Help can be weeks away for a painful shoulder.

Except with Butazolidin® alka.

If it doesn't work in a week, forget it.

But don't forget this about Butazolidin alka

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: one week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

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Butazolidin® alka **Geigy**

Capsules

phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

For complete details,
please see full
prescribing information.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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EJ 5462

COMING EVENTS

March 6—The Council, MSMS Headquarters, East Lansing

March 13-14—Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 26-27—Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 1—47th Annual Beaumont Lecture by Jose M. Delgado, M.D., at Wayne State Medical Society Headquarters, Detroit, 8 p.m.

April 17—The Council, MSMS Headquarters, East Lansing

April 22-25—Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28—17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

May 1—Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8—Mental Health Week

May 4—Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 8-10—Michigan Public Health Association, Inc., Annual Conference, Jack Tar Hotel, Lansing

May 10-11—Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 15—Annual Muscle Symposium Wayne County Medical Society, Detroit

May 18—Kresge Eye Institute Clinic Day, Detroit

May 18-19—Pediatric Clinic Days

June 5—The Council, MSMS Headquarters, East Lansing

July 18-20—The Council, Grand Hotel, Mackinac Island

Aug. 21—The Council, MSMS Headquarters, East Lansing

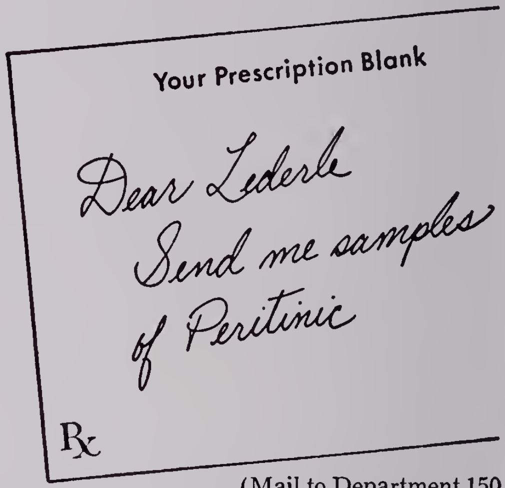
Sept. 22-23-24—MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26-27—MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Nov. 11-15—American Public Health Association Annual Conference, Detroit

Here's what you do to get samples of the

anticostive*
hematinic


Your Prescription Blank

Dear Lederle
Send me samples
of Peritinic

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(Mail to Department 150
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Pearl River, New York 10965)

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
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Vitamin B_1	7.5 mg
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Vitamin B_{12}	50 mcgm
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Folic Acid	0.05 mg
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Bottles of 60

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HISTORY OF WAYNE STATE UNIVERSITY PUBLISHED

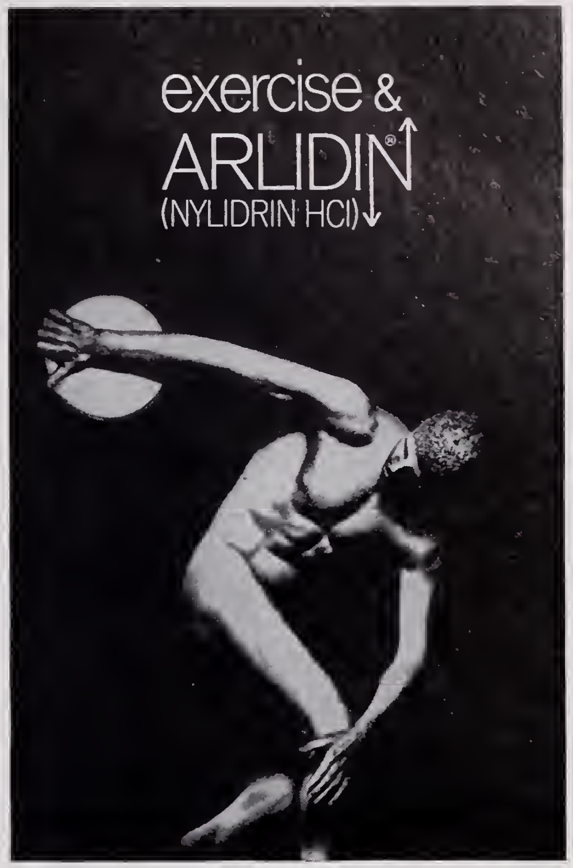
After 11 years of research, interviews, and letter writing, Leslie L. Hanawalt, Ph.D., WSU historian, has completed the history of Wayne State University.

Available now from WSU Press, the 512 page book, *A Place of Light,* was originally commissioned by Clarence B. Hilberry, former president of the university, as a Centennial year project.

The seed from which the present, sprawling university grew was the Detroit Medical College, built on Woodward Avenue after the Civil War. Founders of the Medical College were five bearded medics, young men ranging in age from 29-35: Theodore A. McGraw; Samuel P. Duffield; David O. Farrand; George P. Andrews; and Edward W. Jenks.

The history of the University is told in terms of topics rather than strict chronology. Physicians will especially be interested in the long chapter on the history of the Medical School.

Doctor Hanawalt, a former English professor, has written *A Place of Light* with facility and precision. The book will be enjoyed by any reader interested in the history of Detroit or the history of medicine.



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* 1904 - 1967

Michigan Doctors Describe Vietnam Experiences as Volunteers

BY PETER HOHEISEL
OF THE MSMS STAFF

The 1967 MSMS House of Delegates voted that the several Michigan physicians who "at great personal sacrifice have volunteered their services to the civilians of South Vietnam . . . be given highest praise and commendation for their outstanding work in this valuable portion of the international health activity of the medical profession in Michigan."

Recognizing that many other Michigan physicians have served in Vietnam and other parts of the world under various programs, the resolution commended the nine men who have been involved in the "Volunteer Physicians for Vietnam" program sponsored by the American Medical Association.

THE PRAISE GIVEN these men stands as a symbol of the admiration which the medical profession feels toward all its members who have given of themselves in various parts of the world.

The reasons why physicians, at financial loss and personal hardship, have served in Vietnam vary from "to be where the action is" and "because I'm sick of treating disability cases, and want to see some real disease for a change" to the simple statement "I want to help."

While the motivation is complex, the deed is simple: These men have given of their skill, their time, and indeed of themselves, to a suffering people who desperately need and appreciate their help.

SOME MEN ENCOUNTERED difficulty with supplies and had inadequate facilities; others had little or no difficulty in this area. All found the AMA program well organized and efficient. All found the experience in Vietnam tremendously rewarding, both personally and professionally. Not one of them regrets it.

Following is what these men have to say about their experience:

Robert T. Baugh, M.D., Detroit, General Practice, Long-Xuyen, Aug. 1 - Oct. 1, 1967

"I feel very privileged to have been a member of the volunteer physicians who have participated in Project Vietnam. What little we gave of ourselves to the people was more than repaid by the immense gratitude shown us by the South Vietnamese.

"Even before the onset of hostile activities in Vietnam, the South Vietnamese lived and died with rampant communicable diseases that in most parts of the world had become well controlled decades previously. Diseases ranged from bubonic

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Scholten in Vietnam Now; Elliott Just Returned

Presently in Vietnam is Roger A. Scholten, M.D., a Kalamazoo surgeon. Doctor Scholten will serve in Vietnam until March 14.

Recently returned from a provincial hospital near Saigon is J. Colin Elliott, M.D., of Buchanan.

Michigan Medicine will carry comments by these men in a later issue.

plague, cholera, diphtheria, typhoid, tetanus, leprosy and yaws to raging tuberculosis of entire families.

"Virus infections varied from the well known, such as typhus and poliomyelitis to the obscure such as hemorrhagic fever with its mortality of over 90%. Parasitic infestations were nearly all types, to amebiasis. And then, as was so often the case, multiple system involvements with multiple afflictions and diseases. The life expectancy is said to be 35 years, and nearly 50% of children die shortly before their 5th birthday. This was easy to believe after a short time there.

"Add to this misery the fact that bodily injuries, such as fractures, were often not adequately treated, if at all, because of lack of medical facilities and personnel, to people with acute abdominal conditions who simply died without the benefits of available surgery.

"I saw disease there which I never see here."

"What little we gave of ourselves to the people was more than repaid by the immense gratitude shown us by the South Vietnamese."

"For the physician who serves, there can be no greater reward than the knowledge that he has helped ease the sufferings of individuals who may very well have died had he not been there at the time."

"By caring, we might change these peoples' hatred into friendship, their fears into understanding, for the language of medicine is international."

"I remember one Viet Cong boy I treated who had been shot through both legs. He thought he would be tortured and killed. He was surprised that he was not. He then planned to defect from the Viet Cong."

"The double bonus here, of course, is winning the people over from the Viet Cong which in essence is why we are there."

"American medicine, because of its superior science and pragmatic approach, is sought by people throughout the world."

"Now, compound this need of medical care and treatment with the results of war injuries, (there have been varying medical statistics concerning the ratio of civilian casualties versus military, but 10 civilians to 1 military in many regions has been often stated).

"I believe the American physician has a real responsibility to the people of South Vietnam, to the very young and the very old and the women who seem so often to be in the middle without the relatively good medical care afforded to the South Vietnamese man in the military, because of what the hostilities have caused to their minds, their hearts, and their bodies. Their resultant insecurity, with its attendant deep fear of most strangers, was reborn and nourished through 25 years of nearly constant war beginning with the Japanese during World War II. Their fear was understandable, and their humility and desire to trust us, often with their lives, could only make us very proud to be American physicians and grateful to our colleagues who had come before us to prove to these people we wished only to help them.

"For the physician who serves, there can be no greater reward than the knowledge that he has helped ease the lonely pain and intense suffering of individuals who, had he not taken a relatively short time from his private practice in this country, may very well have died, died simply because had he not been there at the time, there would have been no physician available. Such knowledge makes it very difficult for the physician to leave these people, and, such lasting thoughts thereafter rededicates the physician to responsibilities vested in him.

BAUGH

CAUMARTIN

Hugh T. Caumartin, M.D., Saginaw, Radiology, Binh Dan Hospital in Saigon, April 6-June 8, 1966

"I guess, in every part of the world, God has produced particular beauty. In Vietnam the sun and the air combine to produce a tropical panorama of color. I have seen beauty of nature before, in many parts of the world, but never to this lavish extent. Good and evil sometimes travel part way on the same road but, in Vietnam, they seem to meet — the ultimate in intrinsic beauty with the ultimate in ugliness, a union of heaven and hell on earth. A contradiction: God's intent so obvious in fertile beauty; man's desecration so obvious in reality.

"Vietnam is a country where the average life expectancy is about 35 years, where half the children never reach their fifth birthday. In addition to death from diseases, the situation is aggravated by thousands of civilian war casualties, people who are innocent victims, caught in the cross-fire of ideologies they don't understand.

"This is a war that is not merely a matter of seizing hills and bridges. By mere battle, there is little hope of victory. Even our professional military men say we can't win this war without helping the people so that they will trust us. And in this regard, in medicine, we have a distinct advantage. By caring, we might change these peoples' hatred into friendship, their fears into understanding. For the language of medicine is international. And to give of one's self to those in need makes the parable of the good Samaritan a vital force. Surely America, at its zenith and still ascending, must export its total spirit of democracy to the needy of the world.

"Understanding — unless America can lead the South Vietnamese to a desire for their *own* liberation, then military victory means nothing.

"And so we physicians of America face a challenge.

"And besides, it is a meaningful experience to become totally immersed in the practice of medicine, to enjoy a certain amount of adventure and a feeling of 'being where the action is.' "

Relatives of the native patients perform most of the non-professional medical care in the orthopedic ward at Can Tho. The visitors were all over — because of their strong family ties.

GRADY

NEERKEN

Joseph A. Grady, M.D., Detroit Surgery, Rach Gia, Sept. 11 - Nov. 11, 1967

"The experience is beyond comprehension. The feeling of personal satisfaction is one of the greatest you can achieve.

"There is a great need for general and orthopaedic surgeons; a volume of reconstructive work to be done that is just waiting. I was at a 500-bed hospital, about 150 of these were surgical beds with one general surgeon myself, and one orthopaedic surgeon.

"We had both acute and chronic diseases to be treated. Most of our work was with acute disease with some elective. At the time I left, there was no replacement for me in sight.

"We in medicine have an opportunity to get out and see the world as well as give service. When you work as a physician in a country, you get to know the people in a much deeper way than you would on a cook's tour.

"The AMA has organized the Volunteer Physician Program for Vietnam remarkably well. At each stop we met someone there to instruct and guide us. It is the best organized program I have ever worked with, everything clicked. When I got to Rach Gia everything was set up and ready to go. It was great, I highly recommend it."

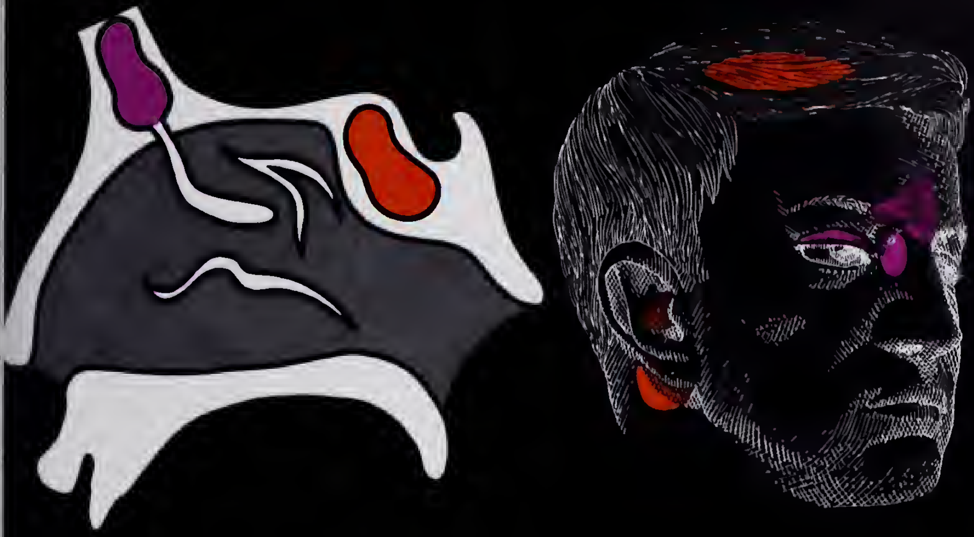
A. J. Neerken, M.D., Kalamazoo, Thoracic Surgery, Nha Trang, Sept. 23 - Nov. 23, 1967

"It was a fantastic experience. Primarily seeing how people live in a different society and how medicine is practiced in another country.

"At first the people were suspicious, it took them time to get to trust you. Many people had first been to the old Chinese doctors who practice things like cupping, ocupuncture, plasters, pinching, and various potions of herbs and barks. By

Continued on Page 257

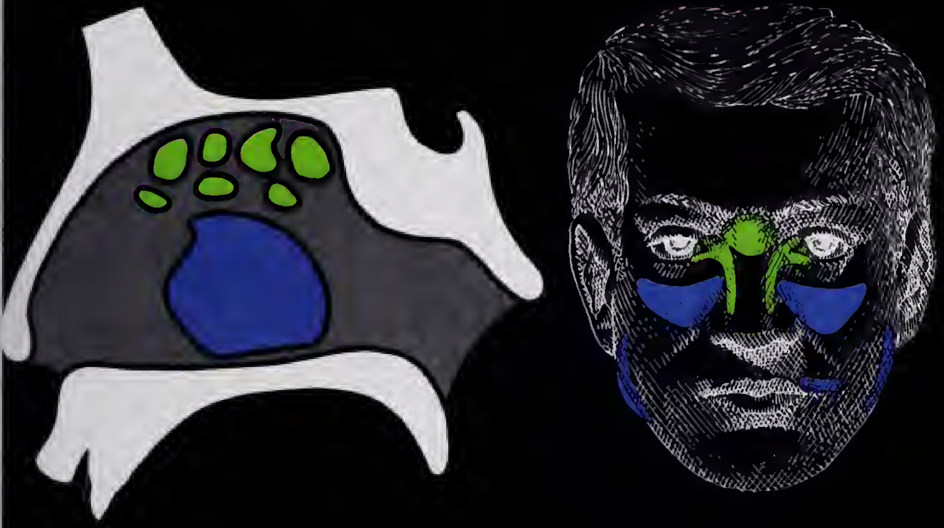
Sources of sinus headache



REGION OF SENSATION

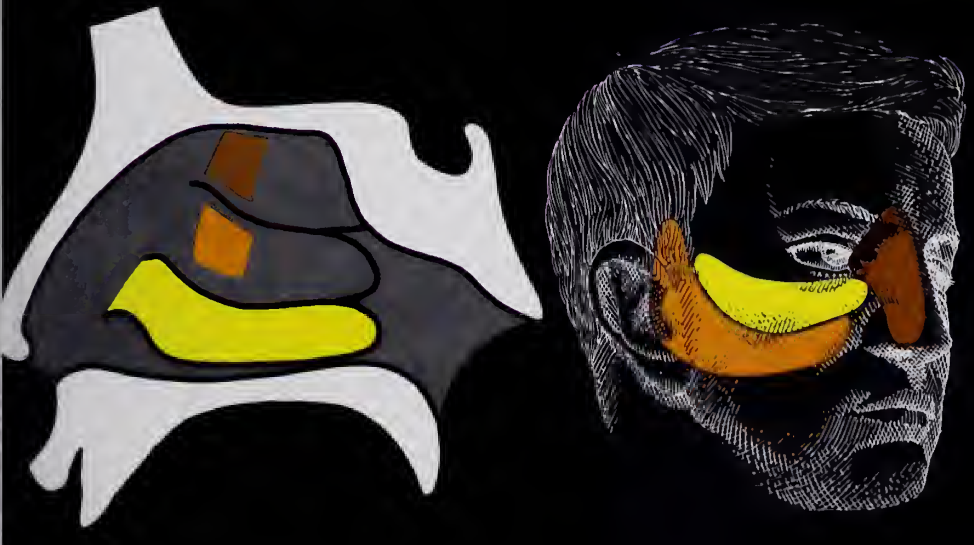
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA
SINUTAB®
FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

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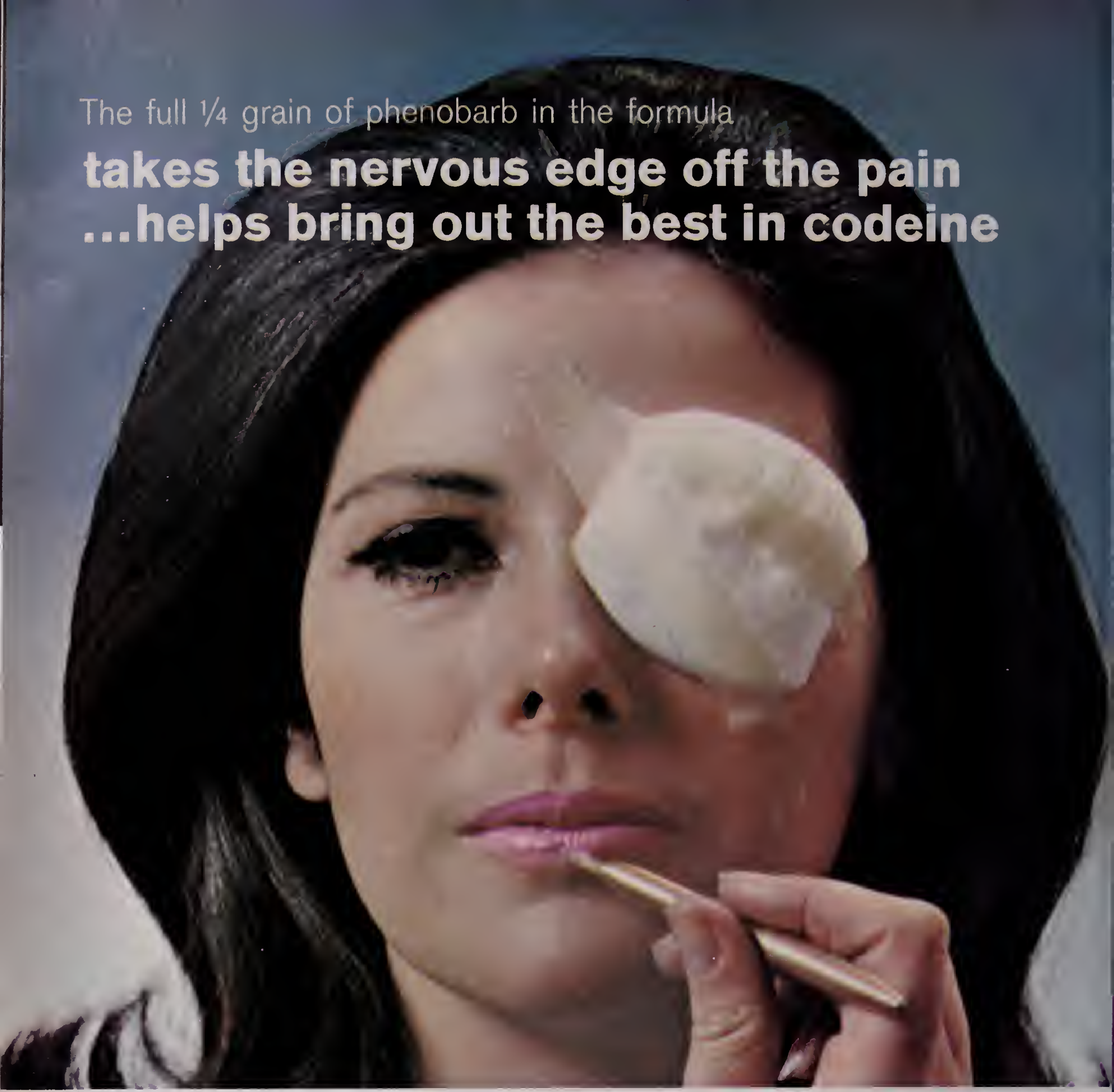
Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS


The full ¼ grain of phenobarb in the formula
takes the nervous edge off the pain
...helps bring out the best in codeine

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the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) *(Warning: may be habit forming)*	16.2 mg.
Aspirin (2½ gr.)	162.0 mg.
Phenacetin (3 gr.)	194.0 mg.
Hyoscyamine sulfate	0.031 mg.
Codeine phosphate *(Warning: may be habit forming)*	¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A·H·ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

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New York, N.Y. 10016

NTZ®
NASAL SPRAY
relieves nasal symptoms on contact

a puzzle
of antacid
complaints

"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

the time that people came to us they were often far along in disease.

"In general we were in good shape with supplies. Our major problem seemed to be the water supply.

"I remember one Viet Cong boy I treated who had been shot through both legs, he thought he would be tortured and killed. He was surprised that he was not. He then planned to defect from the Viet Cong.

"I never felt in danger because everyone knew who we were. The Viet Cong knew that if they or their family were hurt, we would take care of them. In fact, I was tipped off a couple of times when something was about to happen.

"I would highly recommend the AMA program to any physician who is interested."

Lambertus Mulder, M.D., Muskegon General Practice and Trauma, Baclieu, May 1 - July 1, 1966

"South Vietnam medical work is an exciting change of pace and location for two months that excells even a pleasure tour of the Greek Isles.

"Why? Because the people are so appreciative, so different in outlook and character. Because the Viet Cong under my care did show, day by day, a gradual awareness of my care for them and a change in attitude from surliness and fear to warmth and welcome. Because the Buddhist Monks always were pleasant and eager to talk with their U.S. friend, no matter the Christian faith he spread.

"I recall an eight-hour canal boat trip: helping a family during a fire on their sampan, the careful caution of the 12 machine gunners who rode along side and fanned out ahead of us on shore.

"Language is a challenge that excites one when you begin to make yourself understood: When you walk streets far off the beaten path and surprise the villagers with a Caucasian face but a Vietnamese hello. But you are more surprised than they when you cannot find a street in town where someone does not know you and call out 'Cho ong Bacsi' — doctor.

MULDER

SULFRIDGE

A father carries his wounded daughter into the Provincial Hospital at Can Tho.

"I gained a lack of fear in speaking Vietnamese at a party given in our honor. I gained the friendship of the local Hospital Chief, as well as many, many other people in Baclieu, my station town.

"What did I gain from an attack of Dengue? Nothing!

"Back home our citizens want to know what is going on, with our medical work; with the people we obtain contact with the average Vietnamese citizen — language barriers or no.

"For these reasons I would encourage other physicians to come along with us to Vietnam."

Hugh L. Sulfridge, M.D., Saginaw, Orthopaedic Surgery, Can Tho, April 7 - June 7, 1966

"Much of my life in Can Tho was quite similar to what one had in his resident training in a busy city hospital. In my instance it was like the work that I did in the Detroit Receiving Hospital. We worked as a team. There was a tremendous esprit de corps, and all of us regretted the termination of our two months stay.

"Had it been planned such that we could have stayed longer, I am sure every one of us would have enjoyed a much longer tour. Unfortunately, for the average civilian doctor in private practice it is almost prohibitive for him to extend his tour much longer than two months without a great deal of sacrifice and a great deal of planning in the future.

"A run-down of the first day will give some idea of the type of cases we were seeing and this seemed to hold true more or less for the entire two months of my stay in Can Tho.

"A six-year-old boy, right hand partially blown away, hand grenade.

"Twenty-four-year old female, left femur, compound fracture, penetrating wound abdomen, rifle.

"A twenty-year-old male, compound comminuted fracture of the femur, three young adults, compound comminuted fractures of the tibia and femur, shrapnel and gunshot.

"Twenty-year-old male, right face and neck gunshot, partially blown away compound comminuted fracture of mandible and maxilla, rifle.

"Eighteen-year-old male, right hand and right elbow compound comminuted fractures, rifle.

"In addition to this there were seven gunshot wounds or penetrating wounds, abdomen requiring lapcratomies.

"The highest number we acquired in one day was thirty-four, all civilians, mainly women and children, wives of a home defense unit and their children caught in a Viet Cong mortar attack.

"We are definitely winning friends and influencing people. I do not wish to imply that the American is especially loved by the Vietnamese. He is respected and he is liked because he is lending a hand, I think in a Christian way. The double bonus here, of course, is winning the people over from the Viet Cong which in essence is why we are there. So whether we put the buggy before the horse or the horse before the buggy makes little difference here.

"We are there in a missionary way, in a Christian way, and we are there to win the Vietnamese away from the Viet Cong. I feel extremely privileged to have been a part of this project."

Alfred B. Swanson, M.D., Grand Rapids
Orthopaedic Surgery, Canto-Danang-Saigon, Total of four South Vietnam trips 1962-64-66-67

"I do not consider my service in South Vietnam as a great personal sacrifice and of no greater personal risk, than many of the things that we do. I think the reason for our going other than the fact that we enjoy the trip, the people and the work, is that we feel concerned about what happens over there.

"I think we also feel, and increasingly so after repeated visits, that the professionals who go into these under-developed countries and provide a needed service, are America's best diplomats. The humanitarian good that is done, is certainly of prime concern. However, the secondary effects of winning a people away from the attractions of Communism, are just as great.

"The people in Asia need something to aspire to. They need the inspiration of American skilled volunteers who are interested in helping them to change their lives to the good. America is filled with dedicated, skilled people from all walks of life who could meet this challenge. Our problem is to recruit and mobilize them and provide them with the equipment with which they need to work.

"The medical problems are so intertwined with the social and economic deprivement existing in the emerging nations, that medicine can and should be the spearhead in their rehabilitation.

"American medicine, because of its superior science and pragmatic approach, is sought by people throughout the world. It is the easiest thing that we have to sell. American medicine, therefore, has a responsibility and American doctors have an opportunity, for enriching their lives with a wonderful experience of giving."

SWANSON

WADE

Want to Volunteer For Vietnam? Details Available from AMA

MSMS members interested in obtaining the details about the AMA Volunteers for Vietnam program may write to:

Volunteer Physicians for Vietnam
American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610

The International Health Committee of MSMS is currently studying various aspects of overseas medical work. One of the main concerns of the Comittee is to promote an increase of medical aid to the civilian population of South Vietnam. The Committee feels that the current U.S. budget for medical aid to civilians is very inadequate.

Franklin V. Wade, M.D., Flint
Surgery, Phu Vinh, July 15 - Sept. 18, 1967

"It is very difficult to make an accurate statement as to what I may, or may not, have gained

One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Fort Washington, Pa.

from my experience in Vietnam. The major personal gain was that of personal satisfaction in having been able to provide some measure of surgical care for these very deserving and appreciative people.

"It is evident that much of the necessary medical help that these people receive would not be possible if it were not for American physicians in these provincial areas. In addition, it was very gratifying to be able to assist the American military physicians who are doing such a splendid job in this effort.

"Although contact with the Vietnamese physicians is certainly limited, I think that the accumulated influence of American physicians in Vietnam is bound to be beneficial to the Vietnamese physicians.

"Finally, I think that the effort of the American physician in Vietnam tends to cancel out some of the devastating efforts of the war and indicate to the Vietnamese people that a positive effort is being made to improve their lot, instead of the inherent destructiveness of warfare. Each individual physician is, in effect, an ambassador in a limited way; and, as such, is bound to create a measure of good will."

BEAR

Edward S. Bear, M.D., Formerly of Detroit, Working now toward Ph.D. in Pharmacology at Columbia; Danang, July 10 - Sept. 1, 1967

"I think it was a valuable experience medically and personally. You don't see psychosomatic problems, only the very sick get to see a doctor. I saw disease there which I never see here. Also it was an opportunity to see medicine in another country.

"The AMA is doing a good job. John Miller, an AMA administrator in Saigon did a fantastic job getting doctors in and out.

"There is a great need for internists in Danang. Two of us had 90 patients with TB. The only difficulty was an occasional problem with facilities and supplies."

Mead Johnson—pharmaceuticals created for your specialized clinical needs

She relies on your contraceptive advice

She can expect to continue Oracon for years

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Only 4.4% of patients taking Oracon discontinued it because of side effects

Oracon in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue Oracon comfortably. For years.

Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of Oracon, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing Oracon

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of Oracon in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with Oracon. Therefore, if such tests are abnormal in a patient taking Oracon, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. Oracon should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Oracon therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Oracon therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, Oracon should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Oracon may mask the onset of the climacteric. The pathologist should be advised of Oracon therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

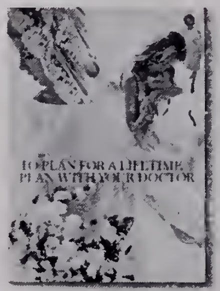
Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

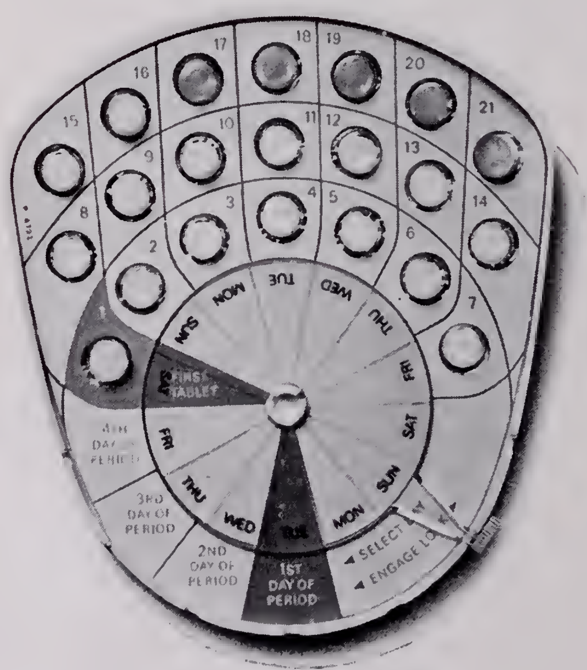
Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.





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Health Council Helps Place Nine More in State

Recent placements by the M.D. Placement Service of the Michigan Health Council have included the following: Andre Michaud, M.D., Jackson; Antanasio Fajardo, M.D., Oakwood Hospital, Detroit; Hugh McCullough, M.D., Sturgis; Wilbur VanderYacht, M.D., Saline; James O. Shaw, M.D., Bay City, (Locum Tenens); Phillip Fry, M.D., Muskegon; Raymond Bernreuter, Saline; Michael Sabbagh, M.D., St. Clair; and Jacques Hochglaube, M.D., Lansing.

SAYS COMPUTERS GIVEN WRONG TASK TO DO

Men are too conservative to be efficient information processors, according to an engineering psychologist at the University of Michigan.

"Men fail to become as certain of conclusions as the evidence in their possession justifies," explains Professor Ward Edwards, head of the U-M Engineering Laboratory.

"Understanding and simplifying a problem takes all the wisdom and intuition that experts can bring to it. But actually making the decision is trivial — it can easily be done by a desk calculator or a digital computer," Edwards said.

"Men should process the information as it comes into the system and pass it on to computers that make the decisions. Unfortunately, all such systems in existence now do it the wrong way around; computers process the information and men make the decisions," concluded Edwards.

TEXAS AUTHORITY COMING FOR SINAI CONFERENCE

Col. Haskell Gruber, U.S.A.F., D.C., chief of the orthodontic section at the Wilford Hall Hospital at Lackland, Texas, Air Force Base, will speak on "Early Management of the Cleft Palate Infant" March 6 at Sinai Hospital in Detroit.

Sponsored by the Sinai Hospital Cleft Lip and Cleft Palate Center in conjunction with the Orthodontia Section, the talk will begin at 2:00 PM at the Paul and Helen Zuckerman Auditorium and Conference Center. Program for the afternoon is as follows: 1. Cleft Palate Team; 2. Diagnosis, Prognosis, and Treatment Plan for the Cleft Palate Infant; 3. Pre-Surgical Maxillary Orthopedics; 4. Bone Grafting to the Maxillary Alveolar Arch — When and Why; 5. Combined Cheiloplasty and Bone Grafting in One Procedure; and 6. Secondary Cases — Orthodontics, Bone Grafting — When and Why.

All members of MSMS and their guests are invited.

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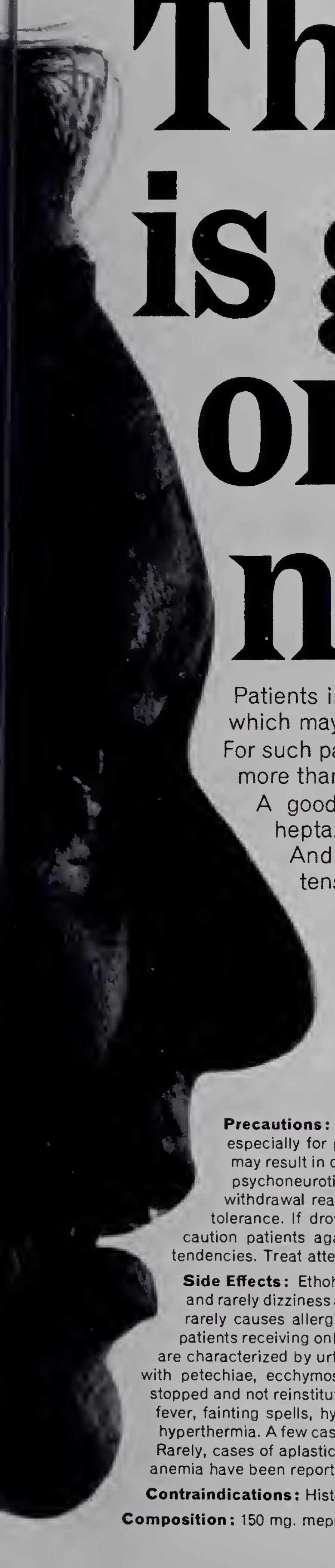

This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS
(meprobamate and ethoheptazine citrate with aspirin)

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Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

VIEWPOINTS

Everybody's Planning

Particularly since the start of the Kennedy administration, a tremendous impetus has been given from Washington, D.C., to federally-funded health programs characterized at their inception by a new concept — "planning." As Dean Wm. Hubbard, M.D., would put it: "Planning has become a very sexy word" in the middle-to-lower echelons of federal department programmers.

First and most visably, mental health burst upon the scene as an area where there was said to have been "far too little planning." Hard on its heels came public health with special emphasis on facilities, manpower and education. "Planning" soon came to be encouraged as an initial activity indispensable to the implementation of *any* new health program — from air pollution control to automobile safety standards to Medicare.

WITHIN THE LAST couple of years a whole new generation of semi-professional, sub-level bureaucrats has been born and reached adolescence — the "planners." Former statisticians, economists, political scientists, and just plain welfare department clerks have found new status — and possible opportunity — as "planners."

The next logical development has been perfectly predictable. It has been the move to now "bring order out of chaos," to undertake "comprehensive" effort. Naturally, this must come about through a comprehensive plan, created by comprehensive planners.

Now federal law 89-749 *demands* comprehensive planning. It is a law with the sharpest teeth of all. Unless a given health project meshes into the comprehensive plan, there will be no federal money for it! (It follows that comprehensive health planners are very important people indeed. In fact if there was a single comprehensive planner in any state with this federal law behind him he could be a czar!).

Michigan, to implement this federal law, already *has* a Comprehensive Health Planning Council — but this Council yet has no executive director, no staff, and no Advisory Committee (the law states that the Advisory Committee must be composed of *more consumers* of service than providers of service). So far, Michigan has set up a five-man group, all of them state government executives. Soon this group will have all the appurtenances.

WHO WILL SUBSTANTIALLY influence the make-up, the deliberations, and the final decisions of this embryo Council?

There has been a fantastic proliferation of "planning groups" within Michigan in the immediate past. One almost expects to confront a new one with each passing day.

Of course, substantial and professionally-oriented groups such as the W. K. Kellogg Foundation's Hospital Division, Blue Cross and Blue Shield, the Michigan Health Council and the Michigan State Medical Society have "planned" for years. But of late, due to the intensified federal impetus and the implied financial threat to specific categorical interests (heart, tuberculosis, cancer, etc.) the planning field has been moved in to *en masse*.

"PLANNING" ACTIVITIES in mental health produced, about three years ago, a foot-high pile of published recommendations of the Department of Mental Health. Most of these have been augmented (or duplicated) by the Mental Health Society and other private groups. About contemporary with this early activity — the first waves of a flood — was the broadgauge "McNerny Report" and its successors out of various Governor-appointed bodies.

Now groups operating under federal grants, and coalitions of categorical health organizations, are bidding to preempt the "planning" field. Most of these bill themselves as "consumer-oriented" but "professionally advised," and they are developing and releasing studies and recommendations by the ream. And their studies are current ones.

There is a "Committee of Forty," tied to the School of Public Health, University of Michigan. There is an even newer "Governmental and Voluntary Executive Forum," which stands ready to advise Michigan's Governor on comprehensive planning. The Greater Detroit Area Hospital Council, the Michigan Welfare League, the Michigan Department of Social Services — to name but a few — are all busily planning.

Before long — in fact, momentarily — Michigan's Comprehensive Health Planning Council will flesh out and go into business. And from which quarter will it seek major guidance? Will it turn to the health professions? These groups have been increasingly accused lately of having long dominated official health agencies — as a part of an obvious campaign to insinuate that the result has been a poor system of providing health care. Will the new Council turn to new groups advertising themselves as "consumer public oriented" and possessed of current surveys, opinions and directions?

The State Comprehensive Health Planning Council *should* turn to such an organization as the Michigan Health Council, which is representative of most health groups, independent and itself citizen-oriented — but will it? The answer, at the moment, can only be "maybe."

The initiative floats in the air. It's up for grabs and everybody's grabbing.

Auxiliary Boosts AMA-ERF

BY MRS. W. G. GAMBLE, JR.,
PRESIDENT, WOMAN'S AUXILIARY

One of the official projects of the Woman's Auxiliary to the Michigan State Medical Society and of the AMA Auxiliary is raising money to support AMA-ERF, American Medical Association Education and Research Foundation. AMA-ERF is the only fund-raising project of the state and national auxiliaries, and money contributed to it supports three programs: Funds for Medical Schools (specific medical school may be designated), Loan Guarantee Fund, and the Institute for Biomedical Research. Doctor, if you are planning a contribution to your medical school, please consider making it through the Auxiliary's AMA-ERF fund.

This year Mrs. Fleming Barbour of Flint, State AMA-ERF Chairman, has vowed that the Auxiliary will surpass its previous contributions. This aim constitutes a major goal, for last year Michigan's donation ranked third among states whose membership is greater than 3,000.

In 1967, Michigan's Auxiliary increased its contribution to AMA-ERF by $4,723.09, making the total contribution an impressive $23,406.78. To illustrate further Michigan's outstanding work, the Macomb County Medical Auxiliary won a National County Achievement Award for the largest contribution to AMA-ERF in its category of membership.

Whereas donations comprised approximately one-fourth of Michigan's total contribution, 75 percent of the money was raised by selling Christmas cards, stationery, charms, playing cards, stuffed animals, etc., and by sponsoring teas, dinners, auctions, and fashion shows. Money is also raised by the use of Memorial Cards, in tribute to a deceased person, and In Appreciation Cards for medical courtesy extended to a physician's family. In Appreciation Cards are used for contributing to the medical school of the physician who treated a physician's family.

AMA-ERF is a major project of the Auxiliary, but there are other projects of equal importance, to which the Auxiliary devotes equal effort. Therefore, Doctor, urge your wife to join the Woman's Auxiliary to your county medical society, and if she is a member, encourage her to devote greater effort to AMA-ERF and the other excellent Auxiliary projects. In addition to the personal satisfaction she will gain from the many worthy activities, you and the profession of medicine will benefit from her dedicated participation!

AMA Restates Purposes

BY LUTHER R. LEADER, M.D.
CHAIRMAN, MSMS DELEGATION TO AMA

We in MSMS — and in our county medical societies, specialty groups, the AMA, et al., — have worked for years in the interest of the public.

We have often felt that the general public, politicians, educators, bureaucrats and others have not been aware of our dedicated efforts to advance health care for everyone. Letters-to-the-editor, platform comments, magazine articles often have blistered the physician and his professional societies without knowing the facts.

Personally, I am glad that the AMA House of Delegates in Houston adopted a positive 11-point document to place the medical organization solid behind continuing efforts to stimulate progress in all aspects of health care in America.

THE EXPANDED STATEMENT of purposes and responsibilities of the AMA declares in detail the broad initiative which is ours to advance health care for everyone.

The statement declares that it is the responsibility of the AMA, as the representative of the medical profession, to continue to foster the advancement of medical science and the health of the American people and to discharge that responsibility through the following means:

1. BY ENCOURAGING THE advancement of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. BY creating incentives to attract increasing

numbers of capable people into medicine and the other health-care professions.

3. BY advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. BY DEVELOPING TECHNIQUES and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities — physicians' offices, hospitals, laboratories, clinics and others — as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. BY MAINTAINING the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

I would urge individual physicians and certainly our component societies to help promote and interpret this new statement of the AMA purposes. The original purpose more than a century ago, "to promote the science and art of medicine and the betterment of public health" is still appropriate but the new 11-point statement will have far more meaning to the general public.

LELAND F. CARTER, M.D., WILL CHERISH HISTORY OF MSMS BY STAPLETON

The MSMS Publication Committee recently received an order and $2.00 from Leland F. Carter, M.D., Detroit, for a copy of *A Century of Service in Medicine,* the MSMS history written by Wm. J. Stapleton, Jr., M.D., our MSMS historian.

And there's a story behind Doctor Carter's request for the Stapleton book . . .

Soon after Doctor Stapleton, who reached his 91st birthday this past Christmas, set up his office on the sixth floor of the David Whitney Building in downtown Detroit in 1932, he was joined on that floor by two physicians, the Carter brothers.

John and Leland Carter set up practice together in 1934. John, who is 76, is now retired in Florida. Prior to his retirement in 1965, John Carter specialized in ear, nose, and throat, and regularly took care of Doctor Stapleton when the need arose.

Doctor Leland Carter, an ophthalmologist, is now 66. Both he and Doctor Stapleton continue their practice at the David Whitney Building.

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Make tuberculin testing routine with every physical examination.

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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

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Pleas for MSMAS Members

BY MRS. NELDA GASPERSON, CMA,
MSMAS PRESIDENT

This article is particularly directed to the doctor whose medical assistant is not a member of the medical assistants society.

Are you aware of the many advantages that membership in this society gains for your medical assistant?

Primarily this organization was formed to render honest, loyal and more efficient service to the medical profession and to the public which it serves.

The Michigan State Medical Assistants Society is comprised of 21 component societies with a total state membership, as of June, 1967, of 739 members. The American Association of Medical Assistants, 12,000 strong, from its inception 11 years ago has been endorsed and encouraged by the American Medical Association.

A resolution adopted by the American Medical Association House of Delegates in 1962 urges all physicians who have medical assistants who are eligible for membership to join and participate in American Association of Medical Assistant programs. At the annual convention of the American Medical Association in Atlantic City, Milford Rouse, M.D., newly elected president in his first report to the House of Delegates said, "Every physician owes it to himself to become acquainted with the objectives and programs of the American Association of Medical Assistants. By charter, their organization can never become a union. Its purpose is to make every doctor's assistant a more knowledgeable and efficient aide."

A NATIONAL CERTIFICATION program has been developed to aid physicians in recognizing top level aides in either the clinical or administrative fields. In order to become a certified medical assistant one must take an examination which is given annually in various testing centers. Five sections of this examination must be passed. Out of 214 applicants tested in 1967, only 74 passed the examination successfully. Eight certified medical assistants reside in Michigan.

An attempt is being made to assist schools and colleges in developing training programs and courses. At the present time, a program is underway to recruit and train medical assistants. This pilot program involves twelve colleges around the country. It is being conducted in cooperation with the American Medical Association and the American Association of Junior Colleges.

Two days of educational programs are part of the American Association of Medical Assistants annual convention. The state convention of the Michigan State Medical Assistants Society also offers educational programs. They annually conduct an educational seminar and an Officers and Committee Chairman Workshop. These programs not only furnish educational material but stimulate fellowship and cooperation among members. Component societies have programs based on subject material from which they derive much information.

IT HAS BEEN SAID that "the medical assistant who is polite, well trained and devoted to her job is a valuable member of the health team." The contributions that this organization offers to the physician in effect are loyalty, devotion to service with the continuing educational standards of self improvement for the betterment of her physician employer.

The Michigan State Medical Assistants Society needs your encouragement and support.

State Doctors Elected To Social Health Board

Two Ann Arbor physicians have been elected to the board of directors of the American Social Health Association representing the midwest region. Elected were Harry A. Towsley, M.D., and Harold J. Magnuson, M.D., both with the University of Michigan Medical School. Lincoln B. Frazier, M.D., Marquette, was chairman of the nominating committee.

STATE BAR FOUNDATION GETS GRANT FROM OEO

Funded at $72,845 in OEO monies, the Michigan State Bar Foundation is grantee for a statewide legal services program established with the primary purpose of providing technical assistance to the State's 15 legal services programs and to communities that want to initiate programs.

The new technical assistance agency will coordinate and assist in administration of local programs whose combined budgets represent 3.8 million dollars in legal services to the disadvantaged.

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Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

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Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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MAILBAG

The Mailbag department is a forum, provided for free individual expression. Letters are published as received and given little or no editing. Responsibility for statements rests with the authors of these communications and not with this journal which strives only to protect the right of individuals to speak for themselves.

On behalf of the Washtenaw Obstetrical and Gynecological Society, I wish to refer to the comments presented by A. Stewart Kerr, Legal Counsel, Michigan State Medical Society in *Michigan Medicine,* July, 1967, pertaining to parental consent for the dispensing of contraceptive pills to minors.

Whereas we realize that there are many ramifications to this issue and that each case must be individually considered, we do wish to present a view expressed by members of this Society who deal with these problems with great frequency.

Each physician has his own rules and regulations by which he practices medicine, whether it be in the order of giving an opinion or in prescribing various medications including oral contraceptives. It is the consensus, however, that the emancipated minor is "emancipated" irrespective of her age and, therefore, in the interest of the individual patient who desires to control conception, we strongly feel that parental consent is not indicated and is not necessary under these circumstances. This girl already has received parental consent for the marriage and all that goes with it.

This is obviously a medical impression — not a legal one — but it reflects the well thought-out ideas and ideals of a group of interested persons who encounter this problem every day. We do not wish to become involved in moral, religious, or legal dialogue, but we are obligated by licensure to practice medicine with the interest of the patient foremost in our minds. To be specific, we are interested in aiding couples who wish to space pregnancies or to prevent them altogether so that they may achieve their aims. Control of conception is particularly important in teenage marriages, which are known to be particularly unstable; at least half of them ending in divorce. If married, a requirement of parental consent when it is unnecessary legally might well hamper their important aims.

George W. Morley, M.D., President
Washtenaw Obstetrical and
Gynecological Society

(Note: The proofreader changed the word "serous" to "serious" in a letter printed in the December issue. We are sorry because the error changed the context of the point being made by the author. The entire letter is reprinted below:)

In response to the viewpoint expressed by Dr. George H. Lowrey entitled "The Dangers of Adeno-tonsillectomy," I feel this "danger" can be answered in two words . . . practically none!

In this day of endotracheal anesthesia and electro-coagulation of bleeding points the procedure should cause a minimum of problems to a doctor trained in throat surgery.

As to the value of tonsillectomy and/or adenoidectomy, I would simply ask the parents of our young patients these questions:

(1) Has your child missed less school time from throat infections since the T & A?

(2) Has your child had less ear trouble since the T & A?

(3) Has your child discontinued his mouth breathing and "stuffy" speech since the T & A?

In my practice the answer to these questions is a resounding *yes*!

I know of no otolaryngologist who advocates the "family plan" or the routine scheduling before starting school. Each patient should be evaluated individually so that unnecessary surgery can be avoided.

In discussing two procedures which should be considered practically worthless, I offer these two in particular:

First, the needless allergic testing and prolonged treatment for nasal obstruction in children due to blocking adenoid tissue.

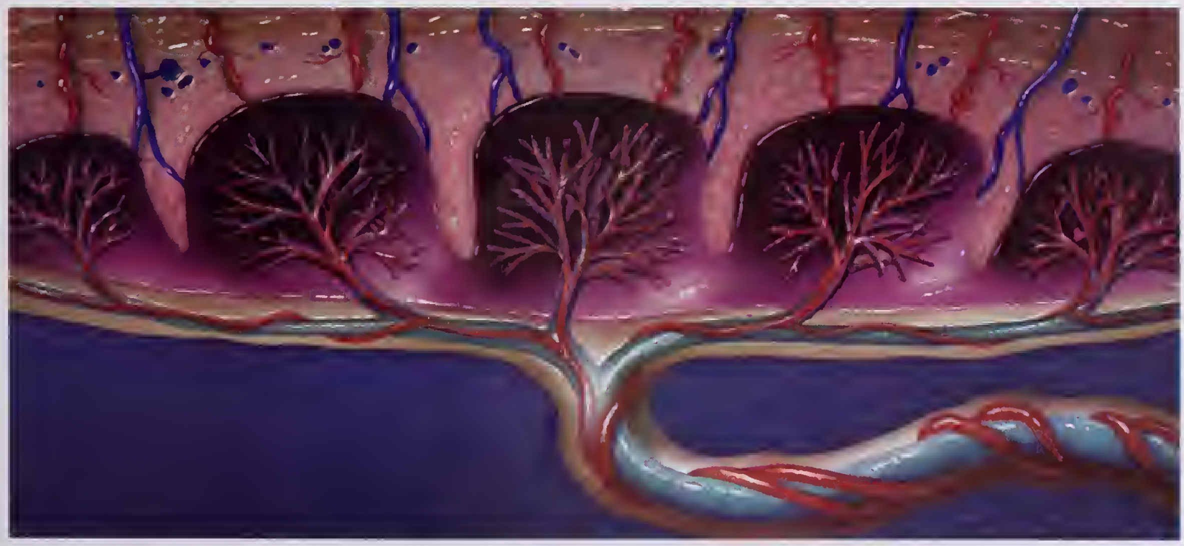
Secondly, the use of huge volumes of antibiotics administered for the child with serous otitis media. Therefore adenotonsillectomy is the wisest course of treatment in many of the ENT problems troubling the pediatric age patient.

Sincerely,
Robert D. Burton, M.D.
Chairman of ENT section MSMS 1966-1967,
Grand Rapids

winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.



this issue: the cold in pregnancy...

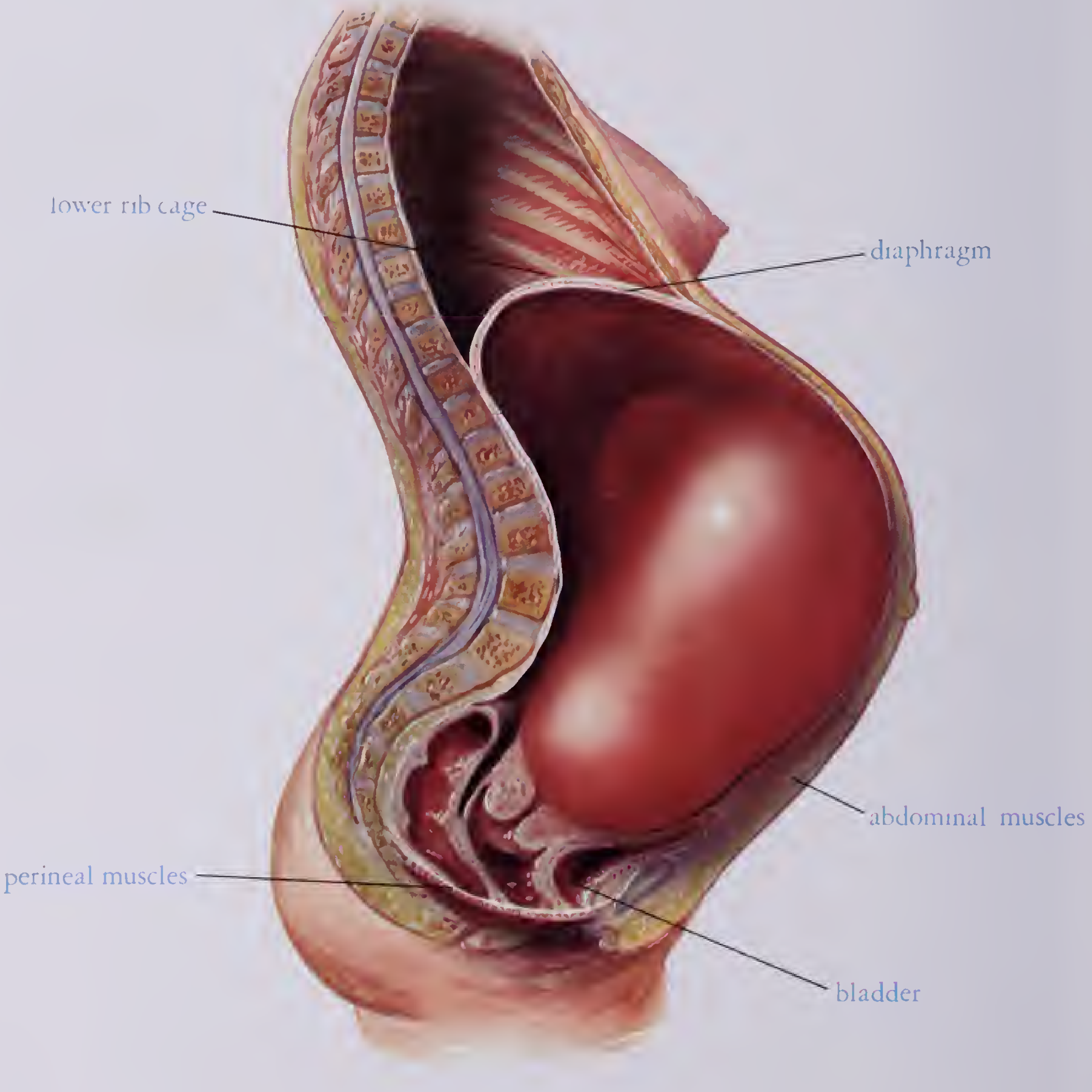
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...

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With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic really works.

Triaminic® *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

Apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.

Relieve his sniffles,
her concern, and about
half your phone calls.
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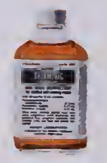

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"Breathing's a snap again," he said gingerly.
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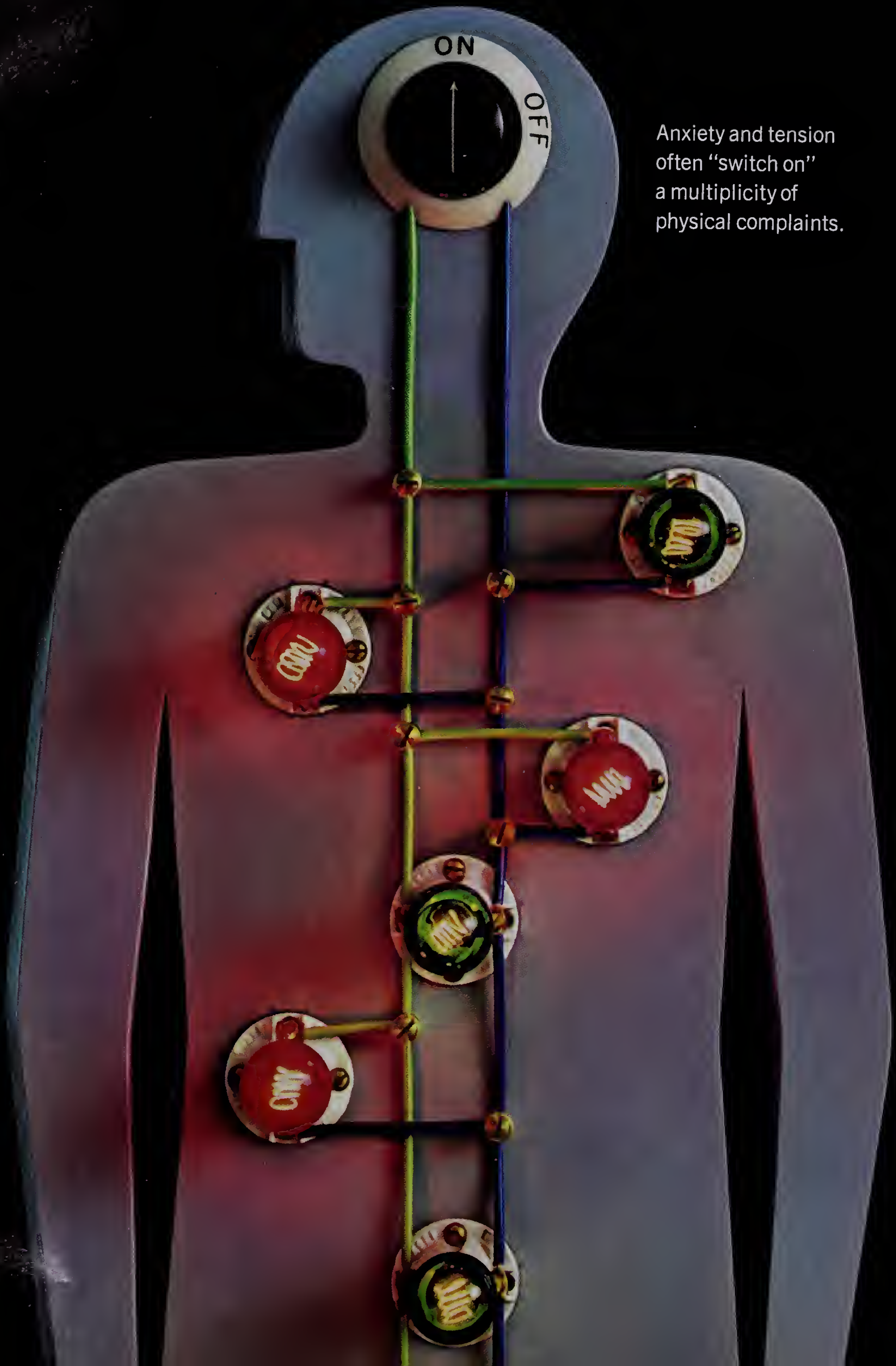

Anxiety and tension often "switch on" a multiplicity of physical complaints.

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Extensive clinical experience, including eleven double-blind studies,[1-11] indicates that Tybatran is an effective agent for the relief of anxiety and tension. It appears to lend itself particularly well to the management of the anxious patient who "somatizes"—whose anxiety and tension find expression in complaints such as headaches,[4,8,10,11] fatigue,[4] insomnia,[2,4,8,9,12] anorexia,[3,8,9] and pruritus.[7]

Two salient features seem to set Tybatran somewhat apart from certain other commonly used tranquilizers.

1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,[4] severe anxiety responded more effectively to tybamate than to meprobamate; in another,[8] symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.[3,6,12,13] (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

For patients in whom anxiety is manifested in any of a multiplicity of physical complaints, Tybatran deserves a clinical trial. These are the challenging patients, those with recurrent, persistent, ever-changing symptoms for which there is no clinical or laboratory evidence of organic disease.

Usual adult dose: one or two 250 mg. capsules 3 or 4 times daily. Adjust to suit individual requirements.

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Prescribing Information

Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

(pronounced TYE-buh-tran)

Tybatran™
brand of tybamate

a tranquilizer with particular usefulness in functional disorders

Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

Bibliography.

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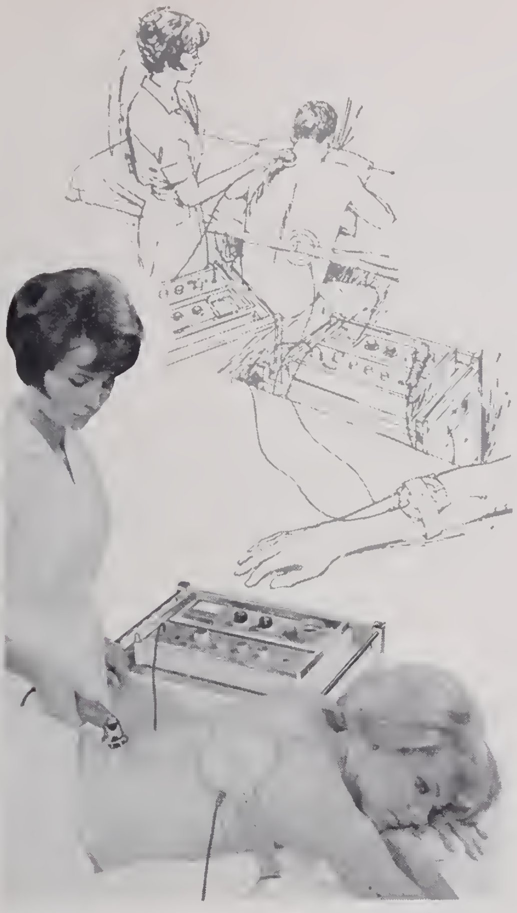
31 QUESTIONS PRESENTED FOR COMPONENT SOCIETIES TO STUDY, DISCUSS

What are some of the subjects which merit—and demand—the attention of the component county medical societies and MSMS?

Thirty-one questions were on the agenda for the three recent MSMS Regional Leadership Conferences. The conferences, authorized by the 1967 House of Delegates, were held at Traverse City, Grand Rapids, and Bloomfield Hills.

1. Relationship of associate membership of osteopaths in county medical societies to hospital staff membership of osteopaths.
2. What changes do doctors need in the abortion laws to permit them to do what they want to do?
3. Should sex education in the schools be liberalized?
4. Program of contacts with legislators.
5. What changes need to be made in the Medical Practice Act?
6. Quackery and cultism conferences.
7. Relationships with podiatrists, optometrists and psychologists, nurses and other paramedical personnel.
8. Planning for potential new vaccine programs (measles and mumps).
9. The effect of use of computers in hospitals on the practice of medicine.
10. The impact of foreign-trained doctors.
11. The medical care team and medical practice patterns.
12. Video tape recorders program.
13. The "care gap" and an accredited training program for continuing medical education.
14. Group practice and hospital emergency rooms.
15. Malpractice insurance and its effect on medical practice.
16. Medical assistants and their training.
17. Michigan Association of the professions (MAP) and Michigan Health Council (MHC) services and support.
18. The purposes of regional leadership conferences and opinion survey.
19. Air, water and land pollution.
20. The doctor draft.
21. Government medical care programs
    a. Medicare and Medicaid
    b. Heart, cancer, stroke
    c. Comprehensive health planning
22. Generic prescribing of drugs.



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23. Voids in preventive health.
24. Unionization of health personnel.
25. New AMA policies and actions as reported in 1967 clinical session, Houston, Texas, December 1967.
26. Expanded services by MSMS
    a. Foreign programs
    b. Others
27. What MSMS publications are wanted.
28. What improvements can be made in medical care distribution.
29. Purposes and progress of the Health Information Research Institute.
30. Executive secretarial and field services of MSMS to county medical societies and councilor districts.
31. Special conference in February, 1968 on medicine, hospitals, and legal concerns.

At all three conferences, workshops were led by MSMS officers and executive staff members. Invited to participate were key component county medical society officers and delegates.

Following are some excerpts from one of the letters received by MSMS after the conferences:

ATTENTION: Mr. Hugh Brenneman

The enthusiasm for and the breadth of knowledge of the many medical problems facing the profession today, which you and your staff possess, is a never ending source of amazement to me. This has never been better demonstrated, to my knowledge, than in this leadership conference program on which you are currently embarked, and to which I appreciate being invited a couple days ago.

I was most impressed that there was no problem introduced, to my knowledge, that you and your staff were not well qualified and willing and anxious to discuss to any depth that anyone wished to proceed to. I do not know how you people do it. You are a great team. I am very proud of you and very pleased and happy in the knowledge that men such as you and your associates are doing your best to represent us in Lansing and on the national scene.

—Frank H. Power, M.D.,
Traverse City

Strong Voice Needed

"We are living in a social, economic and governmental climate in which medicine needs the strongest possible voice in order to state the profession's side of the literally hundreds of issues that are being raised for consideration by the public and by the legislative bodies of our nation."

—Milford O. Rouse, M.D.
AMA President

Save this Article; Changes In Medicare, Medicaid Listed

BY HERBERT MEHLER
OF THE MSMS STAFF

When President Johnson signed into law the Social Security Amendments of 1967 on January 2, several major changes in Medicare and Medicaid occurred.

Listed below are the important revisions. Following each change, where appropriate, you will find listed the old provisions for comparison.

MEDICARE

PAYMENT OF MD's BILLS

PERMITS PAYMENT EITHER TO PATIENT ON BASIS OF AN ITEMIZED BILL (EITHER RECEIPTED OR UNPAID) OR TO THE PHYSICIAN UNDER THE ASSIGNMENT METHOD.

Formerly: Payment only by assignment to physician or to patient on presentation of a receipted bill.

DRUG PROPOSALS

HEW REQUIRED TO STUDY AND REPORT TO CONGRESS BEFORE JANUARY 1, 1969, SAVINGS WHICH MIGHT ACCRUE AND THE EFFECTS ON THE HEALTH PROFESSIONS AND THE DRUG INDUSTRY RESULTING FROM THE POSSIBILITY OF ENACTING TWO PROPOSALS:

1. COVER PRESCRIPTION DRUGS UNDER MEDICARE
2. ESTABLISH, THROUGH A FORMULARY COMMITTEE, QUALITY AND COST CONTROL STANDARDS FOR DRUGS PROVIDED UNDER THE VARIOUS PROGRAMS OF SOCIAL SECURITY ACT.

RADIOLOGISTS' and PATHOLOGISTS' SERVICES

PERMITS PAYMENT OF FULL REASONABLE CHARGES FURNISHED TO HOSPITAL IN-PATIENTS, EFFECTIVE 4/1/68.

These charges are reimbursed 100 per cent. They are not subject to the deductible and coinsurance.

OUT-PATIENT HOSPITAL SERVICES

TRANSFERS HOSPITAL OUT-PATIENT DIAGNOSTIC SERVICES FROM HOSPITAL INSURANCE PROGRAM TO SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, EFFECTIVE 4/1/68.

CERTIFICATION

ELIMINATES PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY FOR HOSPITAL OUT-PATIENT SERVICES AND ADMISSIONS TO GENERAL HOSPITALS.

Retained is certification of medical need for Psychiatric, TB hospital services, ECF, HHA services, inpatient hospital services furnished over a period of time.

ADDITIONAL DAYS

PROVIDES LIFETIME RESERVE OF 60 DAYS OF HOSPITAL CARE AFTER THE 90 DAYS COVERED IN A "SPELL OF ILLNESS" HAS BEEN EXHAUSTED. CO-INSURANCE AT $20 PER DAY APPLICABLE FOR ADDED DAYS OF COVERAGE.

PODIATRISTS

INCLUDES DEFINITION OF PHYSICIAN A DOCTOR OF PODIATRY BUT ONLY TO FUNCTIONS AUTHORIZED BY THE STATE. NO PAYMENT FOR ROUTINE FOOT CARE WHETHER PERFORMED BY PODIATRISTS OR A MEDICAL DOCTOR.

PHYSICAL THERAPY

EFFECTIVE 7/1/68 EXTENDS PROVISIONS TO INCLUDE OUTPATIENT PHYSICAL THERAPY BY PHYSICAL THERAPISTS EMPLOYED BY OR UNDER AN AGREEMENT WITH AND UNDER SUPERVISION OF HOSPITALS AND OTHER PROVIDERS OF SERVICES AS WELL AS APPROVED CLINICS.

PORTABLE X-RAY

PERMITS PAYMENT FOR DIAGNOSTIC X-RAYS IN PATIENT'S HOME OR NURSING HOME. COVERED UNDER SUPPLEMENTAL MEDICAL INSURANCE PROGRAM IF PROVIDED UNDER SUPERVISION OF PHYSICIAN AND PERFORMED UNDER PROPER HEALTH AND SAFETY REGULATIONS.

MEDICAL EQUIPMENT

PERMITS PAYMENT TO BE MADE FOR DURABLE MEDICAL EQUIPMENT NEEDED BY AN INDIVIDUAL, WHETHER RENTED OR PURCHASED.

HEALTH PRACTITIONERS

HEW TO STUDY NEED FOR, AND MAKE RECOMMENDATIONS ABOUT, EXTENSION OF COVERAGE UNDER SUPPLEMENTAL MEDICAL INSURANCE PROGRAM TO THE SERVICES OF ADDITIONAL TYPES OF PERSONNEL ENGAGED IN THE INDEPENDENT PRACTICE OF FURNISHING HEALTH SERVICES.

ADVISORY COUNCIL

HEW WILL ESTABLISH TO STUDY PROBLEMS RELATIVE TO INCLUDING DISABLED UNDER HEALTH INSURANCE PROGRAM AND ANY SPECIAL PROGRAMS WITH REGARD TO COSTS INVOLVED IN SUCH COVERAGE. COUNCIL TO REPORT BY JANUARY 1, 1969.

MENTAL - TUBERCULOSIS

LIMIT ON PAYMENT OF HOSPITAL INSURANCE BENEFITS DURING FIRST "SPELL OF ILLNESS" FOR AN INDIVIDUAL WHO IS AN INPATIENT OF A PSYCHIATRIC HOSPITAL AT TIME HE BECOMES ENTITLED TO BENEFITS IS INAPPLICABLE TO BENEFITS FOR SERVICES IN GENERAL HOSPITAL IF SERVICES ARE NOT PRIMARILY FOR THE DIAGNOSIS OR TREATMENT OF MENTAL ILLNESS.

THE CHANGE REMOVES TUBERCULOSIS HOSPITALS FROM PROVISION UNDER WHICH DAYS IN A TB INSTITUTION IMMEDIATELY BEFORE ENTITLEMENT TO HOSPITAL INSURANCE ARE COUNTED AGAINST THE DAYS OF COVERAGE. THIS CHANGE MAKES THE INDIVIDUAL'S ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS THE SAME IF HE RECEIVED HOSPITAL SERVICES IN A TB HOSPITAL AS IN A GENERAL HOSPITAL.

COORDINATION

ALLOWS STATES UNTIL JANUARY 1, 1970 TO BUY-IN TITLE 18 SUPPLEMENTARY MEDICAL INSURANCE. PERSONS ELIGIBLE FOR MEDICAID BUT NOT RECEIVING CASH ASSISTANCE MAY BE INCLUDED.

Former deadline was January 1, 1968.

MEDICAID

LIMITATION ON FEDERAL PARTICIPATION

STATES LIMITED IN SETTING INCOME LEVELS FOR FEDERAL MATCHING PURPOSES TO 133⅓% OF THE AFDC PAYMENT LEVEL. (FROM JULY - DECEMBER, 1968 THE PERCENTAGE IS 150%, AND FOR CALENDAR YEAR 1969 IT IS TO BE 140%.) THIS AMENDMENT WILL NOT EFFECT FEDERAL MATCHING FOR MEDICAL CARE FOR PERSONS RECEIVING OR ELIGIBLE FOR CASH ASSISTANCE IF NOT INSTITUTIONALIZED.

DIRECT BILLING - MEDICAID

STATES PERMITTED TO MAKE DIRECT PAYMENT TO THE RECIPIENT FOR PHYSICIANS' SERVICES WITH RESPECT TO THOSE MEDICAL ASSISTANCE RECIPIENTS WHO ARE NOT ALSO RECEIVING CASH ASSISTANCE.

Formerly states were required to pay for health services directly to provider.

REQUIRED SERVICES

THE STATES REQUIRED TO PROVIDE FIVE BASIC SERVICES TO ALL MONEY PAYMENT RECIPIENTS. FOR MEDICALLY INDIGENT, STATES ALLOWED TO SELECT EITHER THE BASIC FIVE, OR SEVEN OUT OF FOURTEEN, SERVICES AUTHORIZED UNDER THE LAW, EXCEPT THAT IF NURSING HOME OR HOSPITAL CARE SERVICES ARE SELECTED, STATE MUST ALSO PROVIDE PHYSICIAN'S SERVICES IN THOSE INSTITUTIONS. AFTER JULY 1, 1970, REQUIRES HOME HEALTH SERVICES FOR CASH ASSISTANCE RECIPIENTS.

SKILL NURSING HOME STANDARDS

STATES REQUIRED TO PLACE ASSISTANCE RECIPIENTS IN LICENSED NURSING HOMES ONLY MEETING CERTAIN CONDITIONS. ALSO PROVIDES FOR A PROFESSIONAL MEDICAL AUDIT PROGRAM FOR PERIODIC MEDICAL EVALUATIONS OF APPROPRIATENESS OF CARE IN NURSING HOMES, MENTAL HOSPITALS AND OTHER INSTITUTIONS.

ADVISORY COUNCIL ON MEDICAL ASSISTANCE

ESTABLISHES A COUNCIL OF 21 PERSONS FROM OUTSIDE OF GOVERNMENT TO ADVISE HEW ON ADMINISTRATION.

SAFEGUARDS

REQUIRES STATES TO ESTABLISH METHODS AND PROCEDURES DESIGNED TO SAFEGUARD AGAINST UNNECESSARY UTILIZATION OF HEALTH CARE AND SERVICES, AS WELL AS TO ASSURE THAT PAYMENTS (INCLUDING PAYMENTS FOR DRUGS) DO NOT EXCEED REASONABLE CHARGES AND

Continued on Page 286

Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.
Contraindications: History of sensitivity to meprobamate.
Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.
Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.
Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.
Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.
Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.
Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.
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THAT THEY ARE ON BASIS CONSISTENT WITH EFFICIENCY, ECONOMY, AND QUALITY OF CARE.

FAMILY PLANNING

REQUIRES STATES TO OFFER FAMILY PLANNING SERVICES TO ALL APPROPRIATE AFDC RECIPIENTS. PROVIDES FOR FEDERAL MATCHING, INCREASES AUTHORIZATION FOR MATERNAL AND CHILD HEALTH PROGRAMS, DEVELOPMENT OF DEMONSTRATION PROJECTS FOR THE PROVISION OF FAMILY PLANNING SERVICES FOR THE MOTHERS IN NEEDY AREAS. ACCEPTANCE OF FAMILY PLANNING SERVICES TO BE VOLUNTARY AND NOT A REQUISITE FOR RECEIPT OF ASSISTANCE.

FORMULA GRANT PROGRAM

PROVIDES FOR EARLY IDENTIFICATION AND TREATMENT OF CRIPPLED CHILDREN.

The change amends Title 18 to conform to this requirement.

PROJECT GRANTS

AUTHORIZES PROJECT GRANTS UNTIL JULY, 1972 TO HELP REDUCE INCIDENCE OF MENTAL RETARDATION AND OTHER HANDICAPPING CONDITIONS CAUSED BY COMPLICATIONS ASSOCIATED WITH CHILDBEARING, AND TO HELP REDUCE INFANT AND MATERNAL MORTALITY. PROMOTES HEALTH OF CHILDREN AND YOUTH OF SCHOOL AND PRE-SCHOOL AGE AND TRANSFERS RESPONSIBILITY TO THE STATES BEGINNING JULY, 1972.

OPTOMETRIC SERVICES

ALLOWS PERSONS RECEIVING HEALTH SERVICES UNDER CHILD HEALTH PROGRAMS TO UTILIZE SERVICES OF OPTOMETRISTS WHEN APPROPRIATE.

SOCIAL SECURITY AMENDMENTS

DISABILITY - DEFINITION

PROVIDES MORE DETAILED DEFINITION FOR WORKERS. GUIDELINES WOULD BE PROVIDED UNDER WHICH A PERSON COULD BE DETERMINED TO BE DISABLED ONLY IF HE IS UNABLE TO ENGAGE IN ANY KIND OF SUBSTANTIAL GAINFUL WORK EXISTING IN THE GENERAL AREA OF RESIDENCE AND ALSO PROVIDES A SPECIAL MORE RESTRICTIVE DEFINITION APPLYING TO WIDOWS AND WIDOWERS.

BLINDNESS

CHANGES DEFINITION OF DISABILITY SO THAT A PERSON "INDUSTRIALLY BLIND" (i.e. VISUAL ACUITY OF 20/200 OR LESS CORRECTED OR A VISUAL OF 20 DEGREES OR LESS) IS DISABLED.

The change amends visual acuity of 5/200 or less corrected.

INCREASED BENEFITS — and COSTS

The new law provides for increased benefits of 13% for beneficiaries. Higher benefit checks are first payable in February, 1968 and will be reflected in the March checks.

An increase of benefits also means an increase of the tax on earnings. The amount of earnings now subject to tax and used in the compilation of benefits rose from $6,600 to $7,800 on January 1, 1968.

For the self-employed the tax is now 6.4% and will steadily increase to 7.9% in 1987 and after.

AMA Supports S.780 Now in Congress

The American Medical Association supports all except one provision of legislation (S.780) that would expand the federal government's role in the federal-state program to curb air pollution.

In a letter to the Senate Subcommittee on Air and Water Pollution, F. J. L. Blasingame, M.D., executive vice-president of the AMA, pointed out that the AMA has been directing the attention of physicians and other health workers to the problems of air pollution through a series of meetings and its publications. He also noted that the AMA has supported such legislation in past years.

"In spite of past legislation and on-going federal, state and local programs which are carried on in cooperation with private industry, the American Medical Association recognizes that air pollution continues as a major environmental problem," Dr. Blasingame said. "Increased program emphasis on research and development in techniques of air pollution control and abatement is worthy of the support of the medical profession.

"The bill before you contains one provision which we cannot support. Section 107 of S-780 would require the Secretary of HEW to establish emission standards for certain industries. On the basis of present information and understanding of the relationship between emissions and the effect they have on surrounding air, such a requirement is unrealistic and would not accomplish its intended purpose."

NAME JENSEN, GEHRING, FREITAS TO BLUE SHIELD BOARD TO FILL VACANCIES

Three physicians have been elected to the Michigan Blue Shield board of directors to fill vacancies on the board and assure full medical specialty representation.

Elected to one-year terms were William B. Jensen, Jr., M.D., Grand Rapids anesthesiologist and delegate to the American Society of Anesthesiologists; Harold W. Gehring, M.D., chief of orthopedics at William Beaumont Hospital in Royal Oak, and Eugene L. Freitas, M.D., Detroit radiologist and current president of the Detroit Roentgen Ray Society.

The vacancies on the Blue Shield board were created by the death of Harold Dykhuizen, M.D., Muskegon urologist and surgeon, and the resignations of James B. Blodgett, M.D., Detroit cardiovascular surgeon, and Louis F. Hayes, M.D., general practitioner from Gaylord.

Doctor Blodgett resigned in order to take over his duties as Speaker of the MSMS House of Delegates.

Doctor Hayes resigned from the board to become vice president for medical affairs at Blue Shield.

Doctor Jensen is chairman of the Kent County Medical Society disaster committee and the economics and public policy committee of the Michigan Society of Anesthesiologists.

Doctor Gehring, fellow of the American College of Surgeons, holds memberships in the American Fracture Association, Michigan Orthopedic Society and Clinical Orthopedic Society.

Doctor Freitas is a councilor of the American College of Radiology and a member of the Detroit Gastroenterologic Society.

The Blue Shield board includes 21 physicians and 14 lay members.

S.S. Hope to Help Ceylon People in 1968

The various MSMS members who have served on the S.S. Hope will be interested in the 1968 schedule for the mercy ship:

—February 29, 1968 . . . Leave Philadelphia to begin her new mission to Ceylon and her return to Asia

—March 4, 1968 . . . Arrive Ft. Lauderdale, Florida

—March 6, 1968 . . . Leave Ft. Lauderdale for Colombo, Ceylon

—Early April, 1968 . . . Scheduled arrival, Colombo, Ceylon

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Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B

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PSYCHIATRIC RESIDENCIES: Three year approved program affiliated with Department of Psychiatry, University of Michigan; medical staff of 60, M.S. degree may be obtained; 3-year $8,978/$10,210. 5 year: $10,237/$18,357. GP NIMH: $12,000; limited housing; openings 1968. Joseph Tiziani, M.D., Director of Training, Dept. 8, Ypsilanti State Hospital, Ypsilanti, Michigan.

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POSITION WANTED: General Practice for locum tenens, leading to possible permanent association. Presently available. Reply: Box #2, 120 West Saginaw Street, East Lansing, Michigan 48823.

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PSYCHIATRIC RESIDENCIES: Approved three-year progressive program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, professors, outstanding visiting lecturers. Active Research. Modern physical plant. Salary $8,978; $9,405; $10,213. Five year career program $10,213 to $18,507. Salary increase expected in July. Liberal Civil Service benefits. General Practitioners completed internship four years ago may be eligible for NIMH stipends of $12,000 per year. Write: Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

WANTED: Physician to head Medina County Health Department, population 75,000, available immediately. Liberal vacation policy, attractive working conditions. Contact Donald Gordon, D.D.S., Board President, Area code 216-335-1563 or write, 235 Broad Street Wadsworth, Ohio 44281.

WANTED: General surgeon and Internist to join suburban group. New office buildings in S.W. Michigan. Research, teaching, practice opportunities unlimited in center of "Water Wonderland." Salary or % or both. J. C. Breneman, M.D., 25 Pearl, Galesburg, Michigan 49053.

1ST YEAR RESIDENT OB & GYN University of Michigan teaching hospital in Ann Arbor, Michigan with 2nd and 3rd year residents needs 1st year resident 7/1/68. Private and clinic service. Allied residencies in Surgery, Medicine and Pathology, with rotating interns and U of M Medical students. Non-pyramidal, $675/month $8100 annual). Reply C. W. Newton, M.D., St. Joseph Mercy Hospital, Ann Arbor, Michigan 48104.

POSITION: District Health Director in rural Michigan. Four County unit — population 40,000. Salary range — $17,500-$20,000. One month vacation, sick leave and retirement plan. M.P.H. degree required by end of 3 years. Position available — Jan. 1, 1968. Area is one of farm and resort interest. L. A. Lambert, M.D., West Branch, Mich. 48661.

PHYSICIAN WANTED: Internist-Generalist. Unopposed solo practice in attractive Michigan small town coupled with association with small nearby group. Unusual situation assuring autonomy, excellent income, professional contact and time off. Financial aid available. Call 647-1433 or write 4370 Charing Way, Bloomfield Hills, Michigan.

PEDIATRICIAN: Immediate vacancy for a board certified or board eligible pediatrician or a physician trained in child development to evaluate children in an out-patient diagnostic clinic. The clinic is located in an institution for the mentally retarded, ideally located in the suburbs close to Ann Arbor, Michigan. Salary ranges from $17,497 to $22,968 annually, depending upon experience and education. All Michigan civil service benefits. For further details contact Dr. Jamil Kheder, Plymouth State Home and Training School, Northville, Michigan. An equal opportunity employer.

Urges Two-Year Medical School For Tri-Cities

Samuel D. Marble, Ph.D., president of Saginaw Valley College, suggested at the Bay, Arenac, Iosco Counties Medical Society meeting January 10 that the possibility of establishing a two-year medical school for the tri-city area be studied.

Doctor Marble reported that the county medical societies of Midland and Saginaw were presently studying the potential for such a school in the area.

At the Bay, Arenac, Iosco Counties Medical Society meeting, it was agreed to study the question. Harry F. Vail, M.D., Society president, said "We're pleased to accept Doctor Marble's proposal. We've appointed a committee to study the question and report its findings to the county society."

AREA SAMA GROUPS TO CONFER AT MSU

A newly organized MSU chapter of the Student American Medical Association (SAMA) will host a regional meeting of SAMA groups from 12 midwestern universities Feb. 2-4 at Kellogg Center.

The conference will focus on changes taking place in medical education and the role of SAMA in organizing students for community health programs.

Discussions will be aimed at crystallizing the region's position on various issues to be taken up at the national convention at Wayne State University in April.

The women's auxiliary of SAMA will hold its regional meeting at Kellogg at the same time.

MSU was selected as host in order to give medical students from other schools an opportunity to see how a new medical program is being developed.

Industrial Nurses Hear Kelley, Birmingham

Frank Kelley, M.D., and Donald Birmingham, M.D., both of Detroit, spoke at the Michigan State Association of Industrial Nurses 20th annual meeting January 26-27 in Detroit.

Doctor Kelley spoke on "Orthopedics as Related to Foot Problems"; Doctor Birmingham discussed dermatology.

The Association of Industrial Nurses now has more than 500 members in Michigan.

DEDICATES SCHOOL

Hugh W. Brenneman, MSMS executive director, was the principal speaker at the recent dedication of the new building of the Mesick consolidated school.

Mr. Brenneman was a teacher at Mesick in 1936, so his dedicatory address was based on personal knowledge of the community and its schools.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

FEBRUARY 25-28, 1968

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. The program is presented by leaders of medical thought in all fields of medical activity. It is designed to interest the generalist and specialist alike. *THE OUTSTANDING LECTURE PROGRAM IS PLANNED TO KEEP US ABREAST OF SCIENTIFIC DEVELOPMENTS IN MEDICINE.* In addition certain sessions will take cognizance of Socio-economic developments, all affecting the practice of medicine. All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan
Chicago, Illinois 60604

IN MEMORIAM

H. D. Dykhuizen, M.D., Muskegon

Harold D. Dykhuizen, M.D., muskegon urologist and member of the Board of Directors of Michigan Blue Shield, died November 25. He was 59.

Graduated with a B.A. degree from Hope College in 1930, he received his M.D. degree from the University of Chicago's Rush Medical School in 1935. His internship and residency were done at the Washington Boulevard Hospital, Chicago. After three years as an instructor in urology at the University of Illinois, he opened practice in Muskegon in 1939. He was a senior urologist and consultant in urology at Hackley Hospital and Mercy Hospital, Muskegon.

Doctor Dykhuizen was president of the Muskegon Medical Society in 1958. He was a Fellow of the American College of Surgeons, the International College of Surgeons, and the American Geriatrics Society. A diplomate of the American Board of Urology, he was a member of the American Urological Association, North Central Urological Section and the Detroit Urological Society.

He was a former director of the Muskegon Children's Home, had been president of the Mona Shores School Board since 1965 and was a member of the Board of Trustees for Hope College. He had served as national chairman of the Alumni Foundation for Hope College and also the University of Chicago. He was on the finance committee of the Muskegon County Republican party.

His medical fraternities were Alpha Omega Alpha and Nu Sigma Nu.

E. L. Whitney, M.D., Detroit

Elmer L. Whitney, M.D., Detroit ophthalmologist, died December 29 at the age of 81.

Doctor Whitney, who was graduated from the University of Kansas Medical School in 1918, had been a member of the staff of the Ford Hospital in Detroit for more than 46 years. For 30 years he served as chief of the hospital's department of ophthalmology and later was senior consultant in that department.

His professional memberships included the Detroit Ophthalmological Society, American College of Surgeons, and American Academy of Ophthalmology and Otolaryngology.

He was a member of Alpha Omega Alpha and Nu Sigma Nu medical fraternities and a Life Member of the Michigan State Medical Society.

D. F. Kudner, M.D., Jackson

Donald F. Kudner, M.D., Jackson surgeon, died December 13 at the age of 71.

Graduated from the University of Michigan Medical School in 1920, he had been practicing in Jackson since 1923. For more than 20 years he served as examining physician for the Jackson County Selective Service Board. He was a member of the Foote Hospital Board of Managers for 15 years.

In the late 1930's Doctor Kudner was involved in a pioneer effort to require immunization of preschool children against whooping cough, smallpox and diphtheria. He was also instrumental in organizing the practical nurse program at Foote Hospital in cooperation with Jackson Community College.

Doctor Kudner was president of the Jackson County Medical Society in 1949 and had also served the society as secretary and treasurer. He once served as chairman of the MSMS Industrial Health Committee. He was a Life Member of MSMS.

He was a Fellow of the American College of Surgeons and a member of the Industrial Medical Association. His medical fraternities were Alpha Omega Alpha and Nu Sigma Nu.

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*LICHT, SIDNEY, ORTHOTICS, Etcetera. New Haven, Conn. 1966. p.390

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VOLUME 67, NUMBER 4—FEBRUARY 1968—ALL ABOUT HEALTH PLANNING CONFERENCE

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MICHIGAN MEDICINE

An Open Letter
To Every Member of The Michigan State Medical Society
From Robert J. Mason, M.D., Chairman, MSMS Council

This will announce a new and unique meeting which is designed to serve every member of MSMS.

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Do you want to learn more about:

— Can costs of malpractice insurance be lowered?
— How to testify in court
— How to get more "health manpower" to help you
— How to affect comprehensive health planning in your community
— How to work for legislation you want passed or defeated

These are only a few of the everyday, vital topics that will be covered at the *"First Annual Michigan Conference for Health Planning and Related Subjects"* in Detroit, February 22-23-24.

The Conference has been carefully planned to provide authentic information by experts, who can answer *your* questions . . . with plenty of time to ask them. On the platform will be attorneys, judges, legislative representatives and physicians; and officials of the AMA, MSMS and other statewide organizations and agencies.

Each day will focus on one or two related subjects:

Thursday, February 22 —
"The Doctors, The Law and The Courts"

Friday, February 23 —
"Health Planning and Its Effect On Private Practice"

Saturday, February 24 —
"MSMS Conference for Officers of Component Medical Societies"

Offered as another MSMS service to members, this program is complete as a one-day, two-day, or three-day session, depending upon your interests.

We believe this first annual conference will be entertaining and as valuable to your practice as the more familiar postgraduate scientific sessions. Further, it will reveal MSMS leadership in the critical areas of legal and legislative affairs, and in medical manpower and health care planning.

PARTICIPATE IN THE "FIRST ANNUAL MICHIGAN CONFERENCE ON HEALTH PLANNING" IN DETROIT, FEBRUARY 23-24-25; — SEE PROGRAM AND RESERVATION FORM INSIDE

The First Annual
Conference for Michigan Health Planning And Related Subjects

Sponsored by the Michigan State Medical Society in cooperation with other statewide health associations and agencies in Michigan

* * *

Thursday, February 22, 1968
Friday, February 23, 1968

—New Center Motor Lodge, West Grand Boulevard at Third Avenue, Detroit; between the Ford Hospital and the Fisher Building.

* * *

Thursday, February 22

"The Doctors, The Law and The Courts"

REGISTRATION — 9:00

Presiding Officer of the Day: B. M. Harris, M.D., Ypsilanti, MSMS President
Morning Session Chairman: A. Stewart Kerr, LL.B., MSMS Legal Counsel

MORNING SESSION (9:30)

LEGAL AFFAIRS —

"Are You Protected — Enough?" Richard DeCamp, LL.B., Legal Department, Medical Protective Company

Malpractice Insurance — you can't afford to be without it and hardly afford to buy it! What's happening in this field, coverage and cost-wise? Why?

"Armor for Your Suit" Jeptha W. Schureman, LL.B., Detroit

A highly experienced defense attorney has some tips for you. They might even keep you out of court!

"Are Your Medical Records Really Yours?" Judge Horace W. Gilmore, LL.B., Detroit, Wayne County Circuit Court

A close look at the physician-patient relationship, particularly the records you keep. Whose are they, Really? Yours? The Patients? And what if litigation is involved?

"Court Rooms Can't Be Fun!" William J. Weinstein, LL.B., Detroit, and William P. Cooney, LL.B., Detroit

A top flight plaintiff attorney and a defense attorney will relate some problems physicians have in court — and mistakes they might have avoided making.

"The Insurance Nearly Everyone Has" George M. Van Peursem, Lansing Representative, Michigan Manufacturers Association

Most of your patients are covered by these two important laws, doctor — Workmen's Compensation and Unemployment Compensation.
When their injury is job-connected, what steps should you take?

NOON

Luncheon — "Meet Your Neighbors"

AFTERNOON SESSION (1:30)

LEGISLATIVE AFFAIRS —

"New Laws to Fit the Times"

The State Bar of Michigan has been working for years toward a better approach to drug addiction, alcoholism, abortion, etc. So have we. Hear the experts tell what is recommended.

Presiding: Melvin L. Selzer, m.d., Ann Arbor, Member of State Bar of Michigan's Special Committee on Revision of Criminal Code

Discussants: Jerold H. Israel, Professor, University of Michigan Law School

Herbert A. Raskin, m.d., Detroit, Chairman, MSMS Committee on Alcohol and Drug Dependence

"Your License to Practice — and How to Keep It"

A searching look at the Michigan Medical Practice Act and the powers the Board of Registration in Medicine can exercise for you, or on you!

Moderator: Lester P. Dodd, d.j., Detroit, MSMS General Counsel

Discussants: Joseph B. Bilitzke, ll.b., Lansing, Assistant State Attorney General

Bernard D. Hirsh, ll.b., Director, AMA Law Department

Irvin J. Kurtz, m.d., Detroit, President, Michigan State Board of Registration in Medicine

"What — More New Laws?"

The Assistant Executive Vice President of AMA, and MSMS' man in the State Capitol, say "probably" . . . Some for the better? The details could be very valuable to you, and your practice.

Presiding: Otto K. Engelke, m.d., Ann Arbor, Chairman, MSMS Committee on Legal Affairs

"National Legislation" Ernest B. Howard, m.d., Chicago, Assistant Executive Vice-President, AMA

"Michigan Legislation" M. A. Riley, MSMS Legislative Counsel

COCKTAIL RECEPTION — CASH BAR (5:00)

* * *

Friday, February 23

"Health Planning as It Affects the Physician, Hospital and Community"

REGISTRATION — 9:00

MORNING SESSION (9:30)

Presiding: James C. Danforth, Jr., m.d., Detroit, President-Elect, Wayne County Medical Society

REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER

"How Would Private Practice Be Affected by Recommendations of the Commission?" Harold Margulies, m.d., Assistant Director, AMA Division of Health Services, Washington, D.C.; Formerly with American Association of Medical Colleges, and Chairman for one of the National Advisory Commission Sections.

A warning has been issued that the recommendations of this Commission will find their way into new federal legislation. How will they change your practice? the hospitals? the medical schools?

"Reactions of a Physician to the Commission Recommendations." George W. Slagle, m.d., Battle Creek; MSMS Past-President and Chairman, AMA Council on Medical Service

Should a concerned physician or alert medical society oppose, attempt to alter, or follow the recommendations? Why should doctors in private practice study the recommendations?

"Voluntary Approach to Health Planning" Harry A. Towsley, m.d., Ann Arbor, President, Michigan Health Council; President, Michigan United Fund; and Chairman, University of Michigan Medical School Department of Postgraduate Medical Education

How are the voluntary groups planning and working together to carry out comprehensive Health Planning and to recruit more medical manpower? What is new in Michigan about super nurses? "almost-physicians"? primary physicians?

NOON

Luncheon — "Meet Your Neighbors"

AFTERNOON SESSION (1:30)

COMPREHENSIVE HEALTH PLANNING (PL89-749)

Presiding: Paul T. Lahti, m.d., Royal Oak, Chairman, MSMS Committee on Governmental Medical Care Programs

"The Law and the National Picture" Vlado A. Getting, m.d., Dr. p.h., Ann Arbor, Chairman, University of Michigan School of Public Health, Department of Community Health Services

Just what does the law say or imply in regard to the care of patients in the office and in the hospital? What did the recent amendments add to the original version of PL 89-749?

"Government Implementation in Michigan of Comprehensive Health Planning" Lieutenant Governor William B. Milliken

What is the status now of plans to implement PL 89-749 in Michigan? What voice will physicians have? What role can the individual doctor play?

MARMP - HEART, CANCER, STROKE (PL 89-239)

Presiding:

"Implementation in Michigan" William N. Hubbard, Jr., m.d., Ann Arbor, President, Michigan Association for Regional Medical Programs and Dean, University of Michigan Medical School

What is MARMP? What are its objectives? How will the grant money be spent? Will the local doctors help in the planning? Will the local doctors be able to serve in a "teaching role?"

"Implications of MARMP to Private Practice" Albert E. Heustis, m.d., East Lansing, Executive Director, MARMP

How will PL 89-239 (MARMP) affect the practice of doctors? Will the needs and wishes of doctors on the local level be considered?

ADJOURNMENT

COCKTAIL RECEPTION — CASH BAR (5:00)

See Page 299 for Saturday Program.

Conference For Component Society Leaders

Saturday, February 24, 1968

Wayne County Medical Society Headquarters, 1010 Antietam Road, Detroit

REGISTRATION — 9:00

9:30 Presiding — Robert J. Mason, M.D., Chairman of The Council, MSMS
"Report of Special Session of The House of Delegates"
James B. Blodgett, M.D., Speaker

10:00 Concurrent Discussion Sessions
Discussion Session One — For Secretaries and Executive Secretaries
Discussion Leader:
Kenneth H. Johnson, M.D., MSMS Secretary
Discussion Session Two — For Other Component Society Officers
Discussion Leaders:
Robert J. Mason, M.D., Chairman of The Council, MSMS
Ross V. Taylor, M.D., Vice-Chairman of The Council, MSMS

11:15 *"Legislative Prospects For 1968"*
C. Darrell Coover, AMA Washington Office
Otto K. Engelke, M.D., Chairman, MSMS Legal Affairs Committee
Vernon V. Bass, M.D., Vice-Speaker, MSMS House of Delegates

12:15 NOON

AWARDS LUNCHEON

Presiding: Robert J. Mason, M.D., Council Chairman
Speaker: The Honorable Frank J. Kelley, Attorney General of Michigan

AFTERNOON SESSION (2:00)

PUBLIC EDUCATION THROUGH A QUACKERY CONFERENCE

Moderator: Ross V. Taylor, M.D., Vice-Chairman of The Council, MSMS

Quackery — The National Picture
Doyl Taylor, LL.B., Director, Department of Investigation, American Medical Association, Chicago

Quacks and Their Devices
Lane Breidenstein, Better Business Bureau of Metropolitan Detroit

Arthritis Quackery
Mr. Jerry Walsh, The Arthritis Foundation, New York City

Nutrition Quackery
Mrs. Diana Place, Consumer Specialist, District Federal Food and Drug Administration, Detroit

MSMS and Component Society Plans for Local Quackery Conferences
Brock E. Brush, M.D., Chairman, MSMS Public Relations Committee

Advance Reservation Form
For First Annual Conference for Michigan Health Planning

To Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

I WILL ATTEND THE CONFERENCE ON

☐ **THURSDAY, FEBRUARY 22**
"Doctors, The Law and The Courts"

☐ **FRIDAY, FEBRUARY 23**
"Health Planning — The Physician, Hospital and Community"

A $10.00 Registration Charge, each day, will include the luncheon. Send no check with this form.

Name ______________________________

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IN DETROIT, FEBRUARY 22-23-24

All Physicians Invited to Participate In Michigan Conference for Health Planning

"See you at the Conference on Health Planning."

That's the new by-word in the hospitals and at medical meetings.

Considerable attention has been attracted by the preliminary announcements about the "First Annual Michigan Conference for Health Planning and Related Subjects," in Detroit, February 22-23-24.

The Conference will concentrate on the following subjects:

Thursday, February 22
"Doctors, The Law and The Courts"
New Center Motor Lodge

Friday, February 23
"Hospital Planning as It Affects
The Physician, Hospital, Community"
New Center Motor Lodge

Saturday, February 24
MSMS Conference for Officers
Of Component Medical Societies
Wayne County Medical Society Building

This issue of Michigan Medicine contains the complete program for the two-day meeting for all physicians at the New Center Motor Lodge, and for the annual "MSMS Conference for Officers of Component Medical Societies." MSMS members are urged to decide today to participate and to mail in the reservation form.

MSMS officials are enthusiastic about the subjects and speakers. "It will strengthen MSMS leadership in the critical areas of legal and legislative affairs, and in medical manpower and health care planning," declares Robert J. Mason, M.D., Chairman, of The MSMS Council. The programs will be of a "clearing house" nature to provide for an "exchange of information and viewpoints."

Many other groups are being invited to join MSMS members at the February 22 and 23 programs.

The Saturday, February 24 program, as in the past, is primarily for the invited county medical society leaders. One of the highlights on February 24 will be the annual Awards Luncheon with Attorney General Frank J. Kelley as the featured speaker.

Physicians and others attending the "First Annual Conference for Health Planning" should make their hotel room reservations directly with the Howard Johnson's New Center Motor Lodge, West Grand Boulevard at Third Avenue, Detroit, Michigan 48202. The Single Rooms range from $12 to $18; Doubles from $16 to $22 and Twins from $18 to $24. Reservations will be held until 6 p.m. unless guaranteed.

The $10.00 daily registration fee for all participants on February 22 and 23 will include the luncheon.

The New Center Motor Lodge (Howard Johnson's) at the left is on West Grand Boulevard at Third Avenue. The Fisher Building is shown to the right. The hotel is easy to reach via the various expressways.

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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All Members Invited
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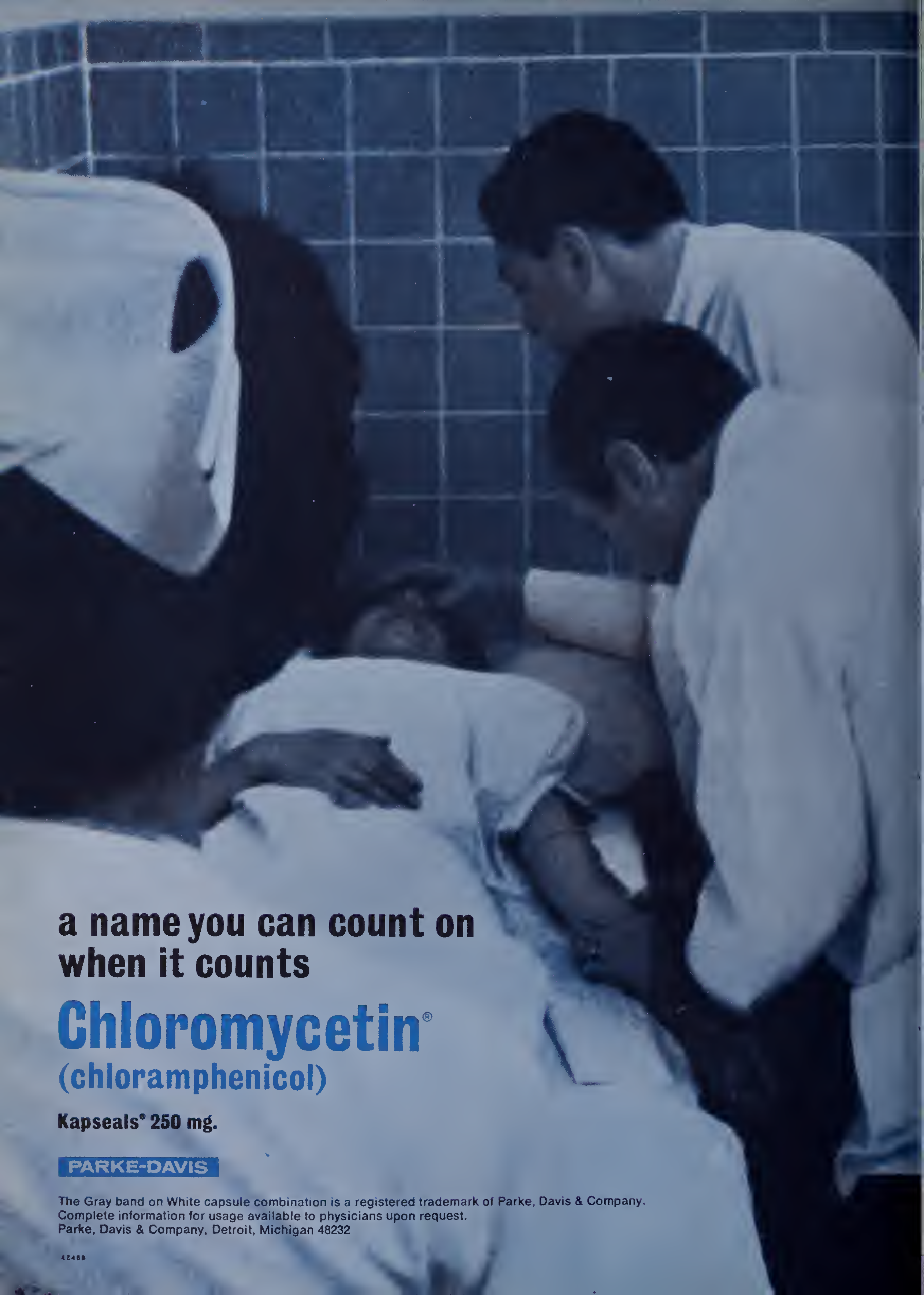
—Sculpture by Giacomo Manzu
Courtesy of Rockefeller Center, Inc.

MICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 5 MARCH 1968

AMONG THE IMPORTANT ARTICLES:

The "Pap Test" can Save More Lives
Progress Report on Michigan Project ECHO
List of Michigan Communities Wanting Doctors
Legislative Support Needed for MSU Expansion

SEE PAGE 369 FOR REPORT OF SPECIAL HOUSE OF DELEGATES



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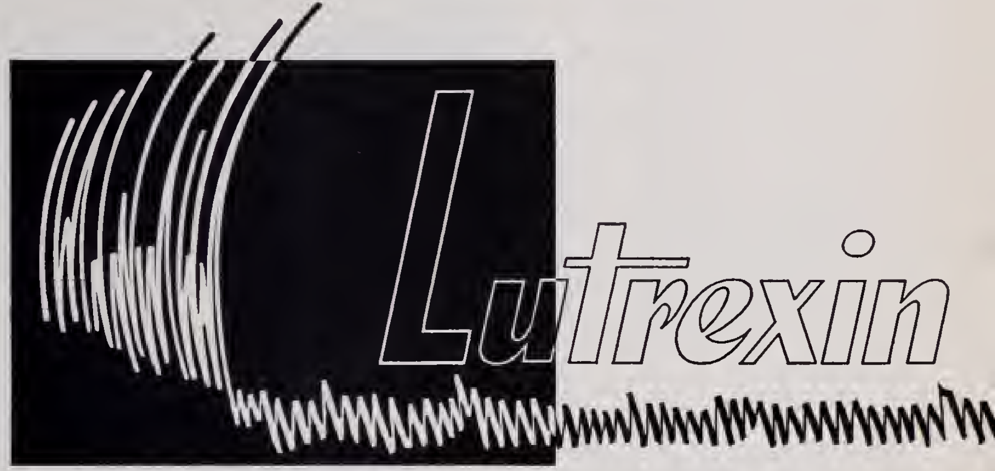

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ABOUT THE COVER:

The cover design was chosen to help promote the Seventh Annual Michigan Conference on Maternal and Perinatal Welfare, in Flint, March 26-27. The mother-child bas-relief was executed by Italy's famed Giacomo Manzu in 1965 as part of the doorway to the Palazzo d'Italia in the Rockefeller Center complex in New York City. The bronze sculptural panel, cast in antique bronze in a Milan foundry, portrays an Italian immigrant mother and child in America. MICHIGAN MEDICINE appreciates the cooperation of the Rockefeller Center in granting permission to print this work by one of the world's foremost living sculptors.

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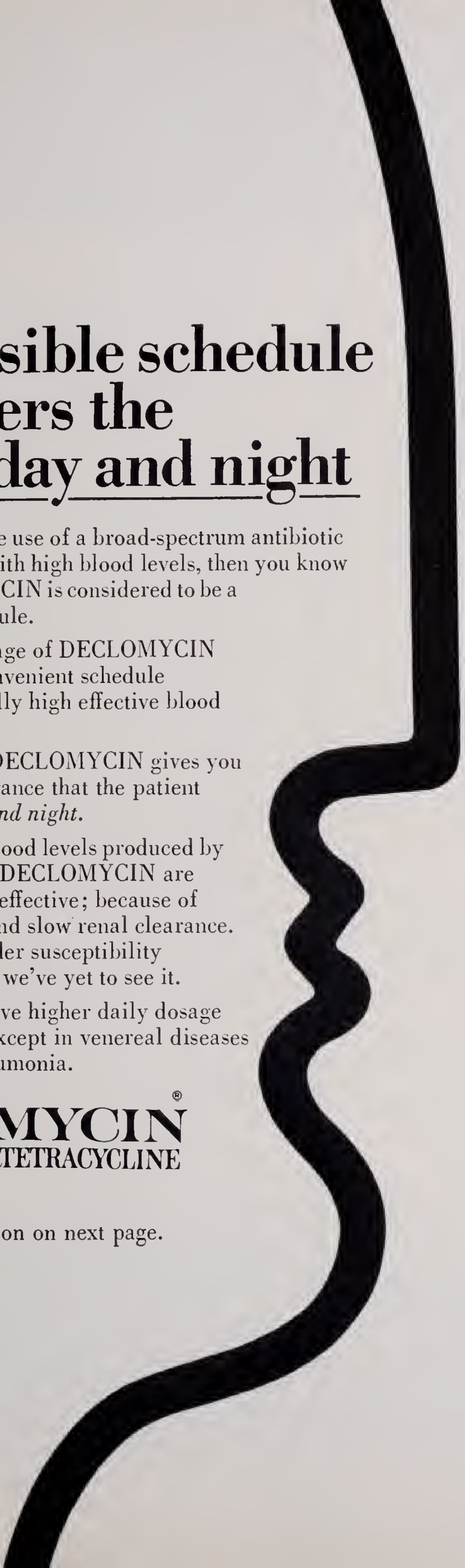

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Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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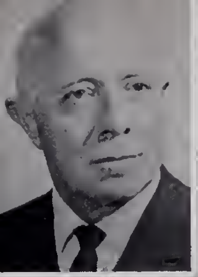

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Playing the Numbers Game

You don't have to go to Las Vegas to get into a pretty fancy numbers game these days.

You can get involved in your own living room — almost every time you pick up the newspaper or listen to radio or television.

The game is played with statistics, with the opportunists twisting them to help him prove some biased view. Social welfare empire builders, politicians, and others know the power of figures and often the target is the doctor of medicine and medical organization.

How do you answer them?

THERE IS NO EASY formula, but the following three suggestions will help you.

First, Recognize the Game. Ask yourself questions like these: "Who is talking?" "Why does he give that ain't-it-awful impression?"

Second, Recognize the Weapons: The opportunist will make his point with glib references like, "according to statistics." When he does that, ask him the source. As physicians and medical organizations, we know how to use vital statistics, numerical charts and tables from authentic studies and organizations.

Third, Have Some Statistics of Your Own: Yes, this will call for study. But the effort will be worth it.

One of the favorite numbers games of the opportunist is to declare that "The AMA doesn't want any more doctors," or "Doctors want to keep down the competition."

THESE GLIB STATEMENTS are so far from the truth. The AMA efforts are tremendous to obtain more doctors. The AMA-ERF has made 35,000 loans totaling $40 million to medical students, interns and residents; AMA members have contributed $50 million to medical schools in the past 10 years; the AMA has actively participated in 11 new medical schools built since 1947; the AMA supported legislation to provide federal grants for medical school construction, etc.

And MSMS has a record equally as impressive. The Health Careers Mobile travels from city to city each week seeking to interest Michigan students in health careers; MSMS has distributed thousands of "Horizons Unlimited" booklets to school counselors, principals, and others; MSMS continues to support efforts to obtain legislative appropriations so the MSU College of Human Medicine can become a four-year school, etc.

NUMBERS WHICH ATTACK medicine — or education, or the voluntary effort, and other segments of our American society — must be studied carefully.

The stakes in the numbers game are big.

There are opportunities today for every MSMS member to polish up some statistics and help expose the opportunists.

* * *

Hope to see many of you at the excellent Seventh Annual Michigan Conference on Maternal and Perinatal Welfare in Flint, March 26-27.

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

See ECHO Article, Please

BY ROBERT J. MASON, M.D.
CHAIRMAN, THE MSMS COUNCIL

In this issue of *Michigan Medicine,* there appears an article reporting on ECHO, a continuing health survey project of the Michigan State Department of Public Health financed by a grant under the federal Comprehensive Health Planning law.

The scope of ECHO (Evidence for Community Health Organization) will expand during 1968 into more counties and cities. Survey work began in 1967 in seven Michigan cities and counties. Plans call for the entire state to be involved by June 1969.

MSMS MEMBERS SHOULD read the article so they will better understand the purposes of ECHO.

The Michigan Department of Public Health's First ECHO Progress Report, October 1967, declared that, "One of the prime concerns of ECHO is the delivery of timely information to those who plan health programs, to those who deliver health services, and to those who need health services."

ECHO seeks to provide an in-depth study of environmental, social and health problems and point up the needs for remedial programs and action in health services on the local level.

THE ECHO PROJECT obviously is a part of federal comprehensive health care programming. The important roles of the county medical society in this new area of public health were outlined on several occasions by Charles L. Hudson, M.D., while he was the AMA President. In part, Doctor Hudson suggested the following "formula" for the county medical society:

"First, the local medical society must make a public commitment. It must put itself and its members on the line as undertaking the establishment of a comprehensive community health system;

"Second, it must take the initiative in drawing together all the elements of the community that have a legitimate interest in health care, to mobilize their combined efforts in a study of existing health facilities and existing needs within the community;

"And third, again it must take the lead in cooperation with all the combined elements in establishing a program to meet whatever needs are discovered."

MSMS members and committees — and the component medical societies — should study the findings of the surveys.

A COUNTY MEDICAL SOCIETY, it seems to me, should be organized to evaluate its medical coverage for the entire community as it reviews ECHO statistics. The statistics and spot maps should help reveal weak spots and problem areas in health care. Specific medical problems, such as chronic diseases, acute illnesses, immunizations, etc., will be pinpointed.

County medical societies will have new facts and insights now upon which to focus their efforts.

The annual report of ECHO declared that ECHO will provide the opportunities "to pull together and interrelate the separate indices of health, both ill health and good health, so that a community profile at the neighborhood level can be made available on a continuing and ongoing basis and a total community program can be developed, responsive to changing demands and changing needs."

PHYSICIANS, BECAUSE THEY will provide the care to improve health across the state, should become informed and involved early as ECHO expands its original eight areas in 1968 to 34.

As MSMS members seek to learn more about the socio-economic influences on health care, the ECHO article becomes recommended reading.

Legislative Support Needed for MSU Expansion

BY BROOKER L. MASTERS, M.D., CHAIRMAN
PUBLICATION COMMITTEE

The Michigan Legislature this year has the opportunity to practice some very good preventive medicine for the benefit of all the people in the state. By acting favorably on proposals of the state's three medical schools to expand their existing programs, the Legislature will help Michigan avoid serious health care problems in years ahead.

The Michigan State Medical Society's House of Delegates has consistently for several years importuned the Legislature to proceed as rapidly as possible with this expansion, realizing that the need for establishing the clinical years at Michigan State University is clear. MSMS has said that the most logical development of MSU's already existing facilities is clearly the most expeditious way to develop more physicians for Michigan's citizens.

THE WARNING SIGNALS have become obvious. The present supply of physicians is dangerously low and the demand for physicians' services is steadily rising. The Bureau of Health Manpower estimates that the United States needs 50,000 more physicians right now. Included in the estimate are 20,000 physicians to directly serve the public, 10,000 to 15,000 psychiatrists, 10,000 interns and residents and 5,000 physicians for teaching, research, public health and administrative positions.

In addition, many young Michigan residents who want to become physicians are being denied the opportunity to do so because the state's medical schools cannot accommodate all of the state's qualified applicants. The MSU College of Human Medicine alone has received 400 applications from persons who would like to fill one of the 26 spaces in the class that will enter this fall.

OF PARTICULAR IMPORTANCE this year are two specific requests from Michigan State University. One of them is for funds to do detailed planning and initiate construction of the university's proposed Life Sciences Building. This building is needed to permit MSU to expand its present enrollment from entering classes of 26 students to entering classes of 64. The building will also house the School of Nursing and the Department of Pharmacology, enabling MSU to expand enrollments in these vital health areas.

The federal government has indicated that it will grant $5 million toward construction of the $10 million structure as soon as state money is committed. The Kellogg Foundation has already granted $625,000, leaving a balance of $4 million to be appropriated by the state. Of this total, MSU is asking for $1.5 million for 1968-69, $1.5 million for 1969-70 and $1 million for 1970-71.

OF STILL GREATER importance over the long run is a request for $390,000 to enable MSU to plan and begin staffing for a third year, the first step toward expansion to a full, medical degree-granting program. The pressing need for this program was well stated and documented in the report of the Committee on Education for Health Care to the State Board of Education in November of 1966. The State Board subsequently adopted the report and has urged the Legislature and Governor to implement its recommendations.

As physicians of Michigan, we must bring the state's need for expanded medical education to the attention of the people. In this crucial case, the people, through the Governor and legislators, have to provide for health care to protect their own future.

Explains Four MD-PAC Goals

BY VERNON V. BASS, M.D.,
CHAIRMAN, MD-PAC

MD-PAC is preparing for its busiest election year.

Nearly everyone agrees that physicians should take an interest in the races for Congress and the state legislature. We have a responsibility to our patients to help select legislators who recognize health needs and dangers, and will act in the best health interest of the citizens. Legislation and law are necessary to protect the individual from fraudulent diets and medicines, narcotics, substandard hospitals and nursing homes, laboratories, impure foods, etc.

Some of the problems in health care such as those provoked by chiropractors can be solved only at the legislative level. If the physician does not take an interest in medical legislation — who will?

Individual physicians would find it difficult to investigate each of the 138 Representatives and Senators. Outstanding leadership in this vital political area is supplied by twenty-four MD's and two wives of doctors. Each congressional district has an MD-PAC chairman on the State Board of Directors. The MD-PAC board carefully assesses candidates and provides you with this information. Candidate support is based on the voting record of legislators. Candidates are not selected on the basis of political party.

Your MD-PAC Board of Directors has four major objectives during this 1968 election year:

1. A substantial increase in MD-PAC membership.

2. More effective candidate support assistance by physicians and wives.

3. More dollar support to selected legislative friends of medicine.

4. Maximum support to six key Congressional candidates through strong professional organization effort that is adequately financed.

MD-PAC and AM-PAC influence is on the rise and will be even more effective in 1968 with your support. If you have not yet joined . . . send $25.00 to MD-PAC, Box 169, East Lansing, Michigan 48823.

When we elect dedicated Americans we need have no fear of big government, socialism or socialized medicine. We need your help in 1968!

Your Medical Assistant

BY GLENN E. MILLARD, M.D., DETROIT

CHAIRMAN, ADVISORY BOARD, DETROIT MEDICAL ASSISTANTS SOCIETY, THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY, AND THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

The intelligent, pleasant, skilled, and highly-trained medical assistant of today is an integral part of the medical team. In addition to her many professional skills, she promotes good public relations for the physician. Medical assistants are organized in a way similar to that of medical societies. They have state, county, and national organizations.

The American Association of Medical Assistants is 12 years old. Many of the founders are still active members. AMA is now an organization of approximately 15,000 members in 44 states. The Michigan State Medical Assistants Society has approximately 1000 members. Active chapters are present in the more populous counties.

THE MEDICAL ASSISTANT has gained much stature in recent years owing to the greater need for assistance to the physician in both clinical and administrative work. There continues to be a shortage of nursing personnel and a greater need for nurses in hospitals, rather than in doctors' offices. The medical assistant can help fill this void.

In addition, approximately one-third of the physician's time is occupied in administrative details such as writing records in long hand, completing insurance forms, explaining hospital costs, discussing insurance coverage, keeping accounts, and writing absentee forms, etc. Your medical assistant can help you with many of these tasks, leaving you more time to devote to patient care.

The medical assistants in their own behalf are stressing leadership, public relations, education, and certification. To be a leader, the medical assistant must know the requisite qualities for leadership. She must have an ability of self-analysis to correct personality problems that detract from her leadership ability; she must know how to get people to cooperate; she must acquire the methods of public speaking and a knowledge of parliamentary law. To provide training for its officers, the Medical Assistants Society has written guides for officers and committee chairmen; MSMAS has leadership training seminars and other aids to help its members be effective leaders.

The AAMA's five-year-old Certification Board is analogous to the various medical specialty boards. Its advisors are physicians, medical assistants, and national educators on a university level. To encourage medical assistants to become certified, MSMAS sponsors yearly educational and organizational seminars. There are now, at junior college and university levels, seven formal medical assistant programs, one or two years in length. Most are credit courses. Educators are becoming increasingly interested in medical assistant courses on a national level, with the United States government underwriting a substantial portion of the expense of the course.

TO ANSWER THE NEED for a formal medical assistants training program, the AAMA is presently developing an approval program for medical assistant courses. Twelve of the schools now offering medical assistant programs will be inspected by physicians, educators, and medical assistants within the next year as a step in determining a national approval program.

A packet is available from the AAMA which outlines the courses and reference books. It also indicates the suggested amount of time to be allowed for each course. This material will be revised when the national survey has been completed. At present, the course outline includes accounting, collection, record-keeping, anatomy and physiology, examining room techniques, sterilization, care of equipment, laboratory orientation, medical law and economics, medical terminology, office skills (secretarial and administrative), written communications, and human relations.

In the not too distant future national computer systems may be established for most patients in the United States in order to facilitate more nearly complete histories. Automated billing is coming into existence in some areas. Centralized record controls will probably be one of the next steps in automation. Computerized and electronic equipment will continue to be more and more important. All of these aids will increase the need for highly skilled medical assistants.

IN ORDER TO accomplish their objectives, the medical assistants have stressed certain pro-

Continued on Page 313

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grams. They are emphasizing the education and certification programs, and are building an image of the medical assistant consistent with the highest standards of professionalism, identifying her with the medical profession, and working hard to show that they do not presume to overstep their limitations of training to infringe upon the work of other members of the health team. They have a code of ethics very similar to that of physicians. They give active support to legislative issues that are important to physicians. The AAMA has a rapidly-growing scholarship program; it stresses philanthropic projects; it is working in close liaison with the Woman's Auxiliary to the AMA. On a national level the AAMA is affiliated with a number of other organizations.

THE MEDICAL ASSISTANT as the physician's partner in caring for the sick deserves our continued interest and support. Physicians should encourage their assistants to join the MSMAS and the AAMA. Any physician who pays his assistant's dues will receive countless returns on his investment. If you give our medical assistants our loyalty, we can expect loyalty from them. Have you urged and sponsored your medical assistant to join the Michigan State Medical Assistants Society and the American Association of Medical Assistants?

Sees Many Challenges

Each of us must take a personal look at how we feel about our individual and collective involvement in the health care of this country.

Hospitals are participating more and more in this activity, politically birthed agencies and communication media are attempting to involve M.D.'s in an increasing manner, and it is our responsibility to face these challenges and to lead to answers rather than becoming shackled by the answers of non-professional people.

Emergency room care and its attendant responsibilities and liabilities, plus the patient who faces the "no new patients accepted credo" are real challenges deserving real answers.

(The above comments were written by Robert Burrell, M.D., President, Kalamazoo Academy of Medicine, and are excerpted from his monthly message in the Academy's Bulletin.*)*

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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The "Pap Test" Can Save More Lives; Comments about Research in Detroit, Nation

ABSTRACT: In the United States each year cervical cancer causes 14,000 deaths. All these deaths could be prevented if every adult woman would have a "pap" smear once a year. But only 18% of the adult women in Michigan had this test. Every physician and every adult woman should cooperate to prevent these 14,000 unnecessary yearly deaths.

BY VAINUTIS K. VAITKEVICIUS, M.D.
KAMRAN S. MOGHISSI, M.D.
BOTH OF DETROIT

Preventive medicine is one of the most important, but also one of the least popular parts of the medical school curriculum. Walter Reed had said that "for each patient saved by the glamorous practitioners of clinical medicine, preventive medicine quietly saves thousands."

When entering the medical school, most of us wanted to become physicians healing the sick. As medical students, we were fascinated by patients exhibiting striking physical findings and complaining of unusual symptoms. None of us were very happy when our instructors assigned us patients with no abnormal findings. Throughout most of our medical lives, our own as well as public attention is focused on the ill patient. This concern with the ill unfortunately detracts our attention from the "well" patients.

THIS IS PROBABLY responsible for the observation recently discussed at a meeting of the Michigan State Medical Society Cancer Committee, that only 18% of adult women living in Michigan had ever been subjected to a cytological examination to detect cervix cancer.

When we first heard this figure, our reaction was one of disbelief.

How could this happen when we are so much concerned about the yearly 300,000 cancer death toll which resists all our efforts. The Federal Government alone yearly spends $164,000,000 for cancer research. Cytological screening of nonsymptomatic women for cervical cancer was proven in innumerable studies to be effective in recognizing early curable cancer. Most gynecologists agree that universal use of this simple office procedure could virtually eliminate incurable cervical cancer and thus save some 14,000 women (most of them relatively young) every year from death.

It seemed to us incredible that the "pap" test, which was introduced by George Papanicolaou more than 20 years ago, would not be used much more widely.

A BRIEF SEARCH for facts, however confirms this figure. Of 200 adult women consecutively admitted to a large private hospital in metropolitan Detroit, only 21 ever had a "pap" smear and only 17 remembered having had such an examination within the past year. An inquiry about the utilization of cancer cytology in other cities throughout the country showed about the same results.

Only in Upstate New York these figures are somewhat better. The Albany Medical School and the New York State Health Department offers to practicing physicians of that area intensive educational programs which include such modern innovations as bi-weekly two-way radio conferences. Probably because of such programs, the utilization of cancer cytology in Upstate New York is among the best in the country. However, Doctor Handy, the man responsible for cancer control activities of the New York State Health Department told us that only 28.3% of Upstate New York women in the age groups 25-54 have been reached by the cancer protection program.[1] Doctor Handy's hopes for the future are modest: "If we're lucky, within the next five years we'll be able to reach one-third of this segment of our population."

In spite of this disappointingly low participation of the women in the cytology programs, carcinoma of the cervix is the only cancer showing a real drop in mortality figures attributable to medical efforts. When detected in situ, this cancer is almost always curable. After its onset, it may take a long time to become invasive.

A large study by Peterson in Copenhagen[2] suggests that at least one-third of these cancers will become invasive within ten years. This fortunate tendency of pre-invasive cervical carcinoma to invade slowly gives us a "grace period." In Upstate New York, the ratio of women admitted to the hospital for treatment of invasive cervical carcinoma to that of patients which carcinoma in situ dropped in the last 20 years from 10:1 to 1:1[1].

This ratio would undoubtedly be much better if *all* women past the age of 20 would have yearly "pap" smears.

THE SITUATION in Michigan is quite comparable with that of the rest of the nation. In a recent article, Anderson and Gunn[3] stated that cervical smears reach only 20% of the adult female population in the United States.

What evidence do we have that "pap" smears are responsible for the improving mortality statistics for cervical cancer?

An intensive campaign to educate San Diego county's physician and patient population caused a drop in the uterine cancer death rate from 10 per 100,000 to 5 per 100,000 in a period of six years[4]. The number of patients detected and operated each year for carcinoma in situ by the staff of the Department of Gynecology at Wayne State University rose from 0 in 1953 to 119 in 1966, while the percentage of patients with invasive carcinoma dropped from 100% to 12% (Figure 1).

Among 30,791 new patients examined at Wayne State University affiliated institutions during the period of five years (1962-1967) a total of 487 carcinomas insitu and 117 invasive carcinomas were found[5]. Similar statistics are avilable throughout the country and throughout the world,

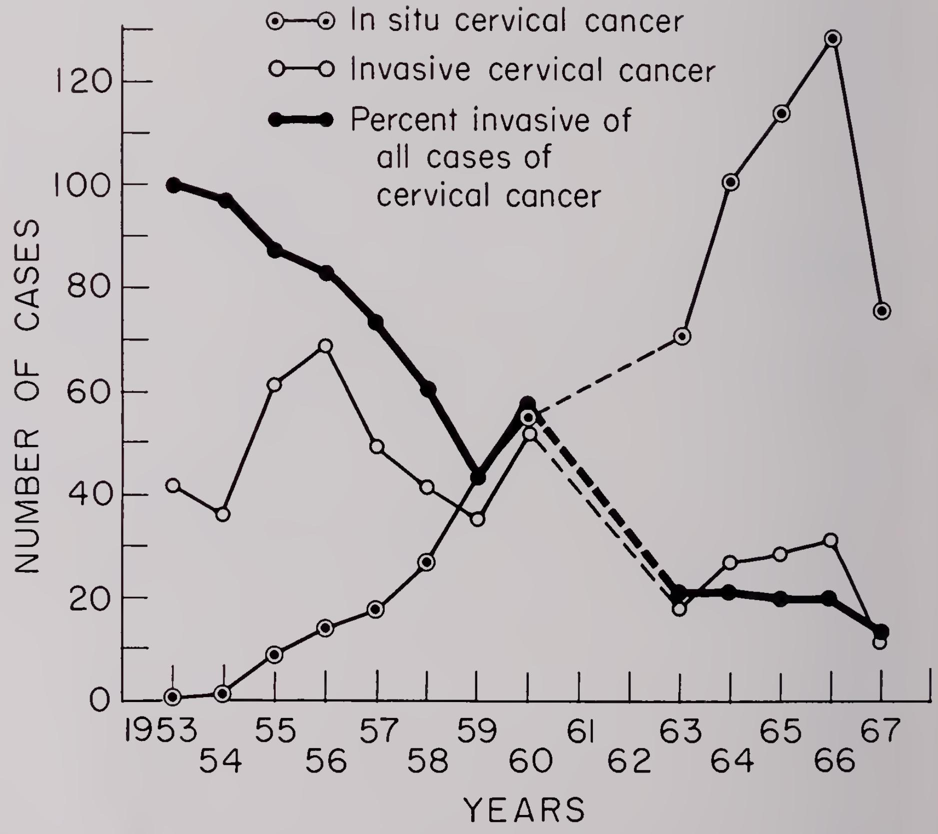

Figure 1: Cervical Cancer detection rate at Wayne State University School of Medicine—Detroit General Hospital program from 1953 to 1967. An extensive cytological screening program was started in January, 1957 and is still continuing. Exact figures for years 1960-1962 are not available. Note the marked decrease in the percentage of invasive cervical cancer from 1953 to present.

wherever the problem of early cancer detection has been studied.

Where and how often should "pap" smears be taken?

There is no question that a complete physical examination carried out by a competent and conscientious physician on an intelligent and cooperative patient followed by indicated laboratory procedures represents the best available means for early detection of any disease. Pelvic examination, in addition to providing an opportunity for direct visualization of the cervix, at which time good quality smears can be obtained, will allow us to detect other pelvic pathologies and therefore should be preferred to any other procedure.

For those patients who do not avail themselves of such an examination, other screening methods such as the collection of vaginal secretions with Davis' cytopipette are available. Cytological smears obtained by this method are about 85% accurate as direct smear[3].

Certainly they are preferable to no examination at all.

However, dependence on such techniques represents an unacceptable assumption that 80% of our female population is either under the care of disinterested or ill-informed physicians, or is too ignorant to seek such help as needed to protect them from fatal cancer. The combined efforts of our medical societies, voluntary health organizations, and mainly the intelligent and trusting cooperation between women and their physicians should be able to eradicate incurable cervical cancer. The importance of such patient-physician cooperation was demonstrated in the same San Diego county's study where 76% of the women receiving "pap" smears admitted that their personal physician was the motivating force for obtaining this examination.

THE INFORMATION is rapidly accumulating that sexual activity starting at an early age is the main etiological factor associated with cervical cancer. Poor personal hygiene of the woman and her partner and sexual promiscuity will increase the frequency of the disease.

A family physician practicing in a suburban community can expect, during a routine examination, to find three to six cervical cancers for every 1,000 patients examined[3].

The physician examining the less fortunate segment of the population will have a much higher rate. The rate of cervical cancer diagnosed as a result of cytological screening during the routine admission physical examination of women admitted to the Detroit House of Correction was 37/1000.[6] A significant number of these women were committed to this institution with the charge of prostitution. The physician responsible for the welfare of imprisoned women can therefore save many more lives from cervical cancer than can a physician in a wealthy suburban neighborhood.

THE RELATIVELY long life history of carcinoma in situ gives us reasonable assurance that if a carcinoma in situ is missed during first examination, it still can be caught in time during the follow-up visit. The exact figure on the frequency of positive "pap" smears among the patients who had previous negative smears is not clear. A number of studies indicate that each year a fairly constant number of new positives will be found in patients who have had a previously negative

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smear. This figure is expected to vary with the social and economic background of women examined. However, for each segment of population year after year, it remains remarkably constant. Anderson et al recently followed 2,175 indigent women for three years. During the first follow-up year he found 2.71 postive smears for each 1,000 patients. During the second year the figure was 2.53, and during the third year 2.76 per thousand.

A similar study at Wayne State University's School of Medicine showed a constant yearly incidence figure of 2.4/1000[5]. Statements are being made that after the first two or three negative yearly smears further cytological examinations are not indicated because of the low incidence of positive smears expected.

IT IS TEMPTING to ask whether the individuals making such statements would rather take a two in a thousand chance of dying from a highly symptomatic cancer rather than to subject themselves to a procedure which carries no mortality, no morbidity, and which can be carried out at less expense than a chest x-ray with a time investment of approximately five minutes. It is unlikely to encounter a patient who would want to take this chance.

The government and institutional programs such as Total Action Against Poverty and cancer detection programs sponsored by the universities and Public Health Service are detecting increasingly larger numbers of pre-invasive cervical cancers among the indigent. Invasive carcinoma of the cervix is becoming less and less common in Detroit General Hospital servicing such a population. Admission data in the large private hospitals in Detroit showed a much less impressive improvement.

The members of the Michigan State Medical Society Cancer Committee agreed that these efforts among our indigent population should continue and should be expanded. They also felt, and this feeling was supported by the Council of theMichigan State Medical Society, that a similar campaign should be instituted by every practicing physician.

EVERY PATIENT ENTERING a physician's office, seen by him on a house call, or treated in the hospital, should be encouraged to return for a yearly physical examination even if his health seems to be perfect. No physical examination of an adult woman is complete without a pelvic examination supplemented by a "pap" smear. These cytologic screenings should start at the age of 20 or younger if the patient is sexually active. Possibly the only exceptions from this rule would be young (below 25) women who never had any sexual contacts and patients whose uterus and cervix have been removed.

All informed physicians agree about the value of periodic chest x-ray examinations for non-symptomatic adults and tuberculin skin testings in children entering school, although even the patients with advanced tuberculosis can be helped by available methods of treatment.

The members of the Michigan State Medical Society Cancer Committee feel that routine "pap" smears for early detection of a disease which after becoming advanced may be fatal is certainly indicated. A simple, painless test invented more than 20 years ago is available for every Michigan woman. In the most remote physician's office in the Upper Peninsula, in the examining room of a busy urban practitioner, or in the crowded clinic serving the indigent patient, a simple non-glamorous "pap" smear obtained with a wooden applicator can save more lives with much less cost than ever will be saved by the most expensive high voltage radiotherapy unit. No cancer surgeon will ever save as many lives as a conscientious practitioner practicing this simple form of preventive medicine.

Every physician's office should be a cancer detection center.

No woman should ever develop invasive cervical carcinoma. We can justify cancer research only by using its results.

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Auxiliary Heart Pump Support on Two Cases Of Myocardial Failure following Acute Infarction

BY ARAN S. JOHNSON, M.D.
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BOTH OF DETROIT

ABSTRACT: The development and testing of devices to provide cardiac and circulatory assistance to failing hearts has become the prime concern of many investigators today.

Reported in this article are two cases of myocardial failure following infarction that were assisted with an auxiliary heart pump.

In recent years, a great deal of attention has been focused on the development of various types of auxiliary and totally replaceable heart pumps to aid failing hearts that do not respond to conventional methods of treatment.

A simple device has been designed and developed by Prisk, et al., that provides this mechanical assistance, when required, following myocardial infarction. This auxiliary pump has been previously described in recent publications as the Substernal Cardiac Massager and Assister. The purpose of this article is to present some interesting clinical data obtained from two treated cases of myocardial failure. The first was an acute infarction while the second was chronic progressive failure several months post-infarction. In the second case, the patient was kept alive and fully conscious with the aid of the pump for thirty-one hours. (See Figures 1, 2, 3, 4)

Case 1

L. K. was a 44-year-old white male truck driver who was admitted through Emergency Room of Harper Hospital on 5-25-67 with a two-day history of severe substernal pain. Past history was essentially negative.

Physical Examination

The patient was a well developed, well nourished, white male in acute distress with respiratory difficulty. He was complaining of vise-like chest pain, radiating into both arms and perspiring profusely. Heart sounds were distant and irregular. Apical rate 100/min. Peripheral pulse rate 100/min. Blood pressure 90/60. Lungs clear. Electrocardiogram was interpreted as an acute anterolateral myocardial infarction.

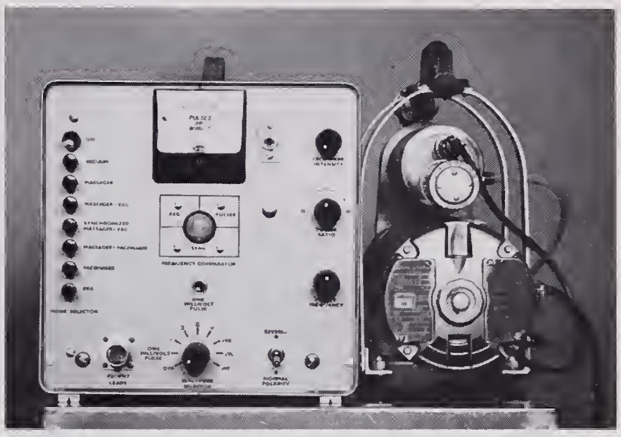

Figure 1: The portable electronic unit on the left, and the cyclic pneumatic pulsator on the right.

Hospital Course

Admitted to the Coronary Care Unit at 12:00 noon on 5-25-67. By 1:45 P.M. the patient developed acute congestive heart failure. Heart rate increased to 140/min, basalar rales heard on auscultation and patient had difficulty breathing. He was digitalized. Heart rate decreased to 88/min, sinus rhythm, with a blood pressure of 100/60. From 4:40 A.M. to 11:00 A.M., the patient developed varying degrees of heart block and finally complete A-V block and syncope. Intravenous Isuprel did not reverse this condition. The patient was sent down to the cardiac catheterization laboratory for insertion of a transvenous internal cardiac pacemaker at 11:00 A.M. ECG at the time showed A-V dissociation, and there was no palpable pulse or blood pressure. The cardiologist was unable to pass the internal cardiac pacemaker beyond the right atrium, although several attempts were made.

Patient developed ventricular fibrillation at 11:40 A.M. External massage, difibrillation and external cardiac pacing were not successful. At 12:17 P.M., the substernal auxiliary balloon pump was inserted into the anterior mediastinum in less

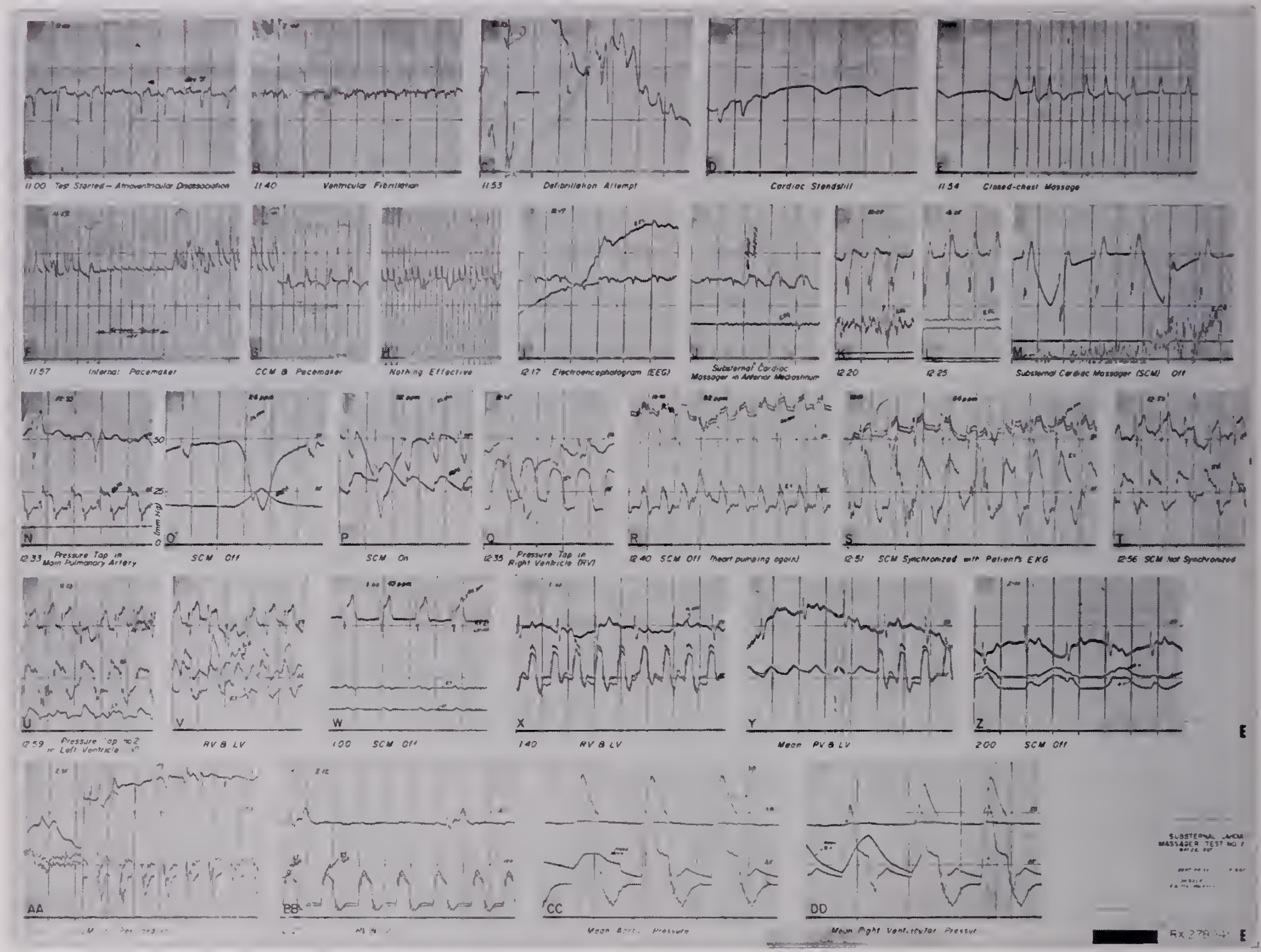
A
11:00 Test Started – Atrioventricular Dissociation
B
11:40 Ventricular Fibrillation
C
11:53 Defibrillation Attempt
D
Cardiac Standstill
E
11:54 Closed-chest Massage
F
11:57 Internal Pacemaker
G
CCM & Pacemaker
H
Nothing Effective
I
12:17 Electroencephalogram (EEG)
J
Substernal Cardiac Massager in Anterior Mediastinum
K
12:20
L
12:25
M
Substernal Cardiac Massager (SCM) Off
N
12:33 Pressure Tap in Main Pulmonary Artery
50
25
0
(mm Hg)
O
SCM Off
P
SCM On
Q
12:35 Pressure Tap in Right Ventricle (RV)
R
12:40 SCM Off (heart pumping again)
S
12:51 SCM Synchronized with Patient's EKG
T
12:56 SCM Not Synchronized
U
12:59 Pressure Tap No. 2 in Left Ventricle
V
RV & LV
W
1:00 SCM Off
X
1:40 RV & LV
Y
Mean PV & LV
Z
2:00 SCM Off
AA
BB
CC
Mean Aortic Pressure
DD
Mean Right Ventricular Pressure
SUBSTERNAL MASSAGER TEST NO 1
Rx 278

Figure 2: Serial monitored graphs from Case #1.

than one minute. Figure 1 represents the actual serial monitoring of the EKG. EKG and pressures of this case graphically show the effectiveness of substernal cardiac massage and assistance.

Analysis of Serial Tracings from Case #1

A and B tracings: Deteriorating EKG from A-V dissociation to ventricular fibrillation. Patient's pupils were widely dilated and nonresponsive to light. C through H tracings: Persistent asystole with ineffectual ECM*, EP** and defibrillation. I through M tracings: Gradual improvement in EKG and EEG with SCM***. During this interval, a fibrillating heart which had gone into standstill was converted to sinus rhythm. N tracing: Cardiac catheter was passed into the main pulmonary artery and with SCM the recorded pressures of MPA were 27/mm systolic, 10/mm diastolic. O tracing: SCM off, pressure MPA dropped to zero and the EKG started to deteriorate. P and Q tracings: SCM on, pressure in MPA 19/11 and in Q, pressure up RV 44/7.5. R tracing: SCM off, sinus rhythm, and RV 28.5/16. S tracing: SCM on and synchronized with the patient's EKG. With synchronization RV increased to 45/10. T tracing: SCM on but off synchronization, the pressure in RV decreased to 35/12. U and V tracings: On SCM, RV 34/13 and LV 56/20. W tracing: Off SCM, ventricular pressures dropped to zero, but good sinus rhythm recorded on EKG. X and Y tracings: On SCM, ventricular pressure up to previous SCM pumping levels. The substernal auxiliary balloon was then removed from the anterior mediastinum and inserted into the pericardial sac. The serial tracings AA to DD show more effective cardiac assistance with the balloon in the pericardial sac. The recorded pressures were as follows:

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* External Cardiac Massager

** External Pacemaker

*** Substernal Cardiac Massager

Systolic mm Hg.	End Diastolic mm Hg.
LV 86	18
RV 67.5	15
LV 88	18
RV 92	16
Aorta 64	20
Aorta 78	28

During the final stages of monitoring, the EKG deteriorated completely, and although the heart was electrically dead the SCM maintained pressure compatible with life. Cineangiocardiogram revealed good movement of radio opaque material (76% Renovest 50 cc per injection) from the right atrium into the lungs with recirculation to the left side of the heart and complete filling of the aorta and its major branches. Left ventricular injection showed good ventricular filling and emptying with the aid of the auxillary heart pump in the anterior mediastinal position as well as in the pericardial sac.

Case 2

G. B. was a 35 year old Negro male with a history of progressive shortness of breath, weakness, rapid heart rate, nausea and vomiting. He was admitted through the Emergency Room of Harper Hospital on 5-28-67.

Past History

This was essentially negative except for an acute myocardial infarction in January, 1967. The patient was digitalized two weeks prior to his admission to Harper Hospital.

Physical Examination

At the time of admission, patient was a well developed, well nourished, 35 year old negro male who was apprehensive, but not in acute distress. Vital signs: BP 110/80 right arm, supine. Pulse 120/min and regular. Respiration 16/min. Lungs: Few coarse rales both bases. Heart: Very distant heart sounds. Apical rate 120/min. Sinus rhythm. Heart enlarged on percussion. Abdomen: Liver down two finger breadths and slightly tender. Extremities: No pedal edema. X-ray of chest: Grossly enlarged heart. Lung fields fairly clear.

Hospital Course

From date of admission to consultation, patient demonstrated progressive cardiac deterioration and irreversible myocardial failure. There was no appreciable response to medical therapeutic measures

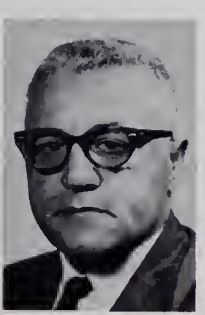
ECG: 7-3-67 Acute Anterior Myocardial infraction
7-6-67 Acute anterior wall infarction with digitalis intoxication

On 7-7-67, the patient was semiconscious. Vital signs: BP 70 systolic on palpation. Pulse 130/min. Respiration 26/min. Abdomen: Liver down two finger breadths.

Clinical Impression

Mechanically failing heart result of extensive myocardial damage and fibrosis.

Substernal auxiliary heart pump assistance was recommended. He was transferred to the Coronary



JOHNSON

CO-AUTHORS

Doctor Johnson is a cardiovascular surgeon in Detroit and Mr. Prisk is an engineer, Research Laboratories Division of General Motors Corporation. The initial clinical studies were done at Harper Hospital, Detroit; the research supported by a special grant from General Motors.

PRISK

Care Unit. The urinary output decreased to an average of 7 cc per hour. BP 40-70 systolic on palpation. Pulse 140/min. Respiration 36/min. Lung bases: Increasing coarse rales. On 7-8-67, at 1:50 A.M., under local anesthesia, the substernal auxiliary heart pump was inserted into the anterior mediastinum at the bedside. The auxiliary heart pump was then synchronized to the patient's ECG. Between 2:30 A.M. and 4:00 A.M., patient had become more responsive, BP increased to 100 systolic on palpation and the urinary output had increased to 90 cc within 1½ hours. 4:30 A.M., vital signs more stable. BP 110/60 right arm on auscultation. Heart rate 120/min. Sinus rhythm. Respiration 20/min. 4:00 A.M. to 6:00 A.M., cardiac function continued to improve with an increase in urinary output to 60 cc every half hour. Vital signs remained stable. The patient was fully

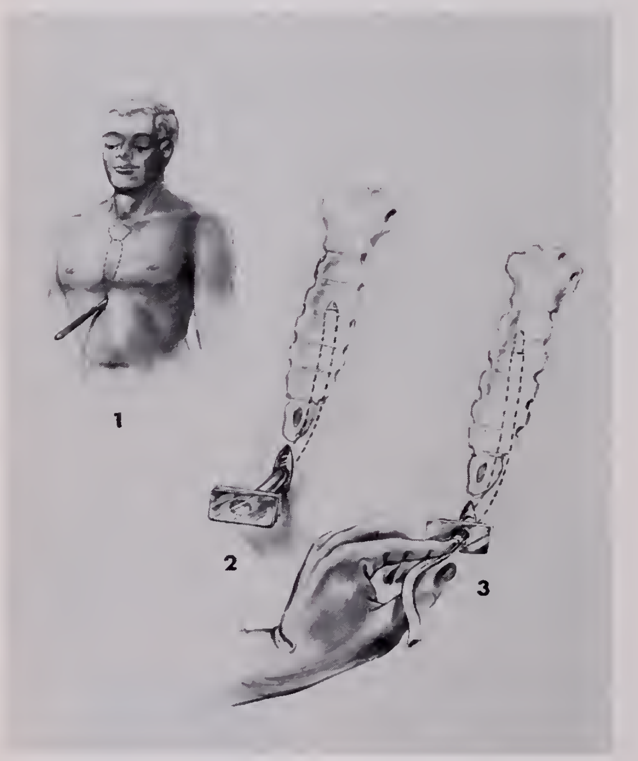


Figure 3: Diagrams showing technique of insertion of the cardiac assister in 3 steps.

1. Small incision tip of xyphoid
2. Substernal trochar manipulated into the anterior mediastinum.
3. Introducing the substernal balloon cardiac assister thru the lumen of the trochar into the anterior mediastinum.

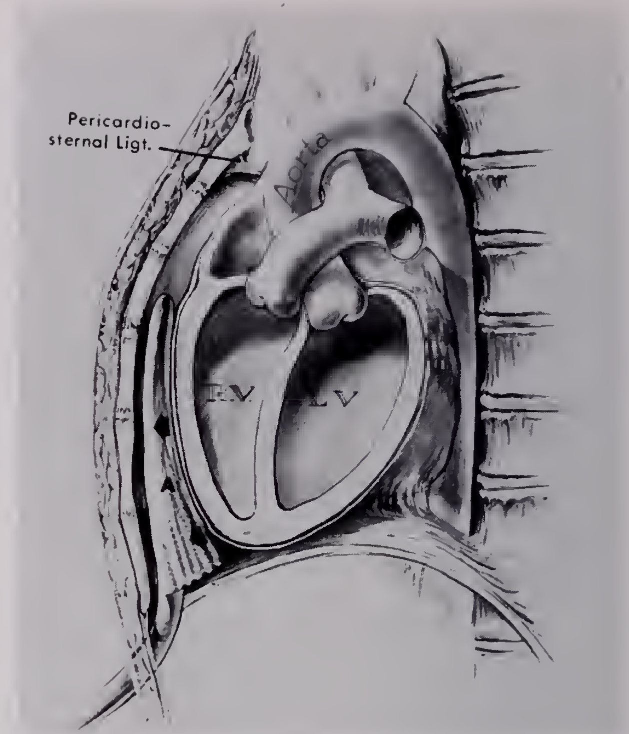


Figure 4: A. Pulsating cardiac ballon assister in diastole (Balloon under vacuum)

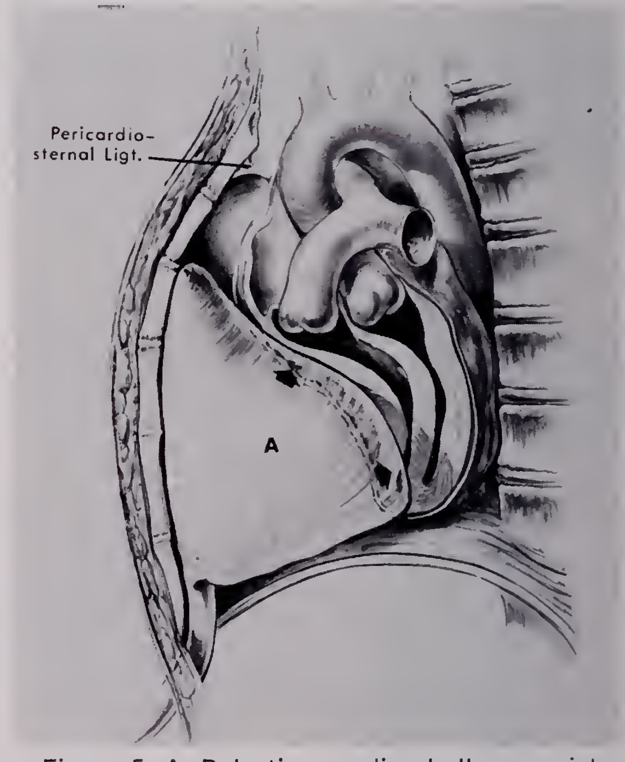


Figure 5: A. Pulsating cardiac balloon assister in systole (Balloon under 15 P.S.I. of pressure.)

responsive and able to talk to his family. On 7-9-67, at 6:30 A.M., cardioscope showed frequent ventricular extra systoles. His urinary output had dropped to 10 cc in the last two hours, heart rate had increased to 138/min and the BP had dropped to 60 systolic on palpation. Patient continued to deteriorate rapidly and died at 9:15 A. M. Total substernal auxiliary pumping time was 31 hours.

Autopsy revealed a grossly enlarged heart. Both right and left ventricles enlarged. Right ventricular wall was very thin, measuring 5 mm in thickness in some areas and the left ventricular 15 mm in thickness. There was diffuse stenosing atherosclerosis involving both right and left coronary arteries with occlusion of the anterior descending branch of the left coronary artery. Histological examination revealed diffuse endocardial and myocardial fibrosis.

Discussion

Scientific data obtained while using the substernal auxiliary heart pump on two patients with acute myocardial infarction. The first patient had developed both mechanical and electrical heart failure following an acute myocardial infraction. From the monitored data, it appears that the auxiliary heart pump in the anterior mediastinum was effective for total cardiac assistance as shown by the ECG tracings in Figure 1. When a uniform electrical QRS complex was obtained and the pump was synchronized with the QRS complex, there was an approximate 30 percent improvement in cardiac assistance by the auxiliary pump. When the pump was placed in the pericardial sac, there was approximately 45 percent improvement in pressure curves over anterior mediastinal auxiliary pumping.

The substernal auxiliary heart pump restored this electrically dead heart to normal sinus rhythm with a cardiac output adequate to maintain tissue life. The pumping was stopped when there was clinical evidence of irreversible CNS damage which had occurred during the attempted insertion of the transvenous cardiac pacemaker.

The second case is a good example of long standing chronic heart failure without CNS damage. The pump was used on this patient after all accepted methods of treatment had failed and patient was developing frequent and more prolonged periods of syncopal attacks due to low cardiac output. While on the auxiliary heart pump, the patient remained mentally alert, maintained stable vital signs and experienced little discomfort. He was assisted for 31 hours before complete loss of myocardial substance and muscle contractility with subsequent irreversible cardiac dilatation and death.

Summary

Use of an auxiliary heart pump on two patients with myocardial failure following acute myocardial infarction has been presented and discussed.

Acknowledgement

Many thanks to Howard A. Klein, M.D., for his interpretation of the electrocardiograms and to Jan Nyboer, M.D., for monitoring of Case #1. Donald Whitney, supervisor at General Motors Technical Center, spent many hours on this project. We are most appreciative of the combined efforts of these gentlemen.

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Regional Enteritis Presenting As Acute Arthritis

ABSTRACT: The case of a 15-year-old girl who presented with acute peripheral arthritis seven months before developing classical regional enteritis is described. Synovial fluid and synovial membrane biopsy data, with serological studies, over a two year period of follow-up, are presented. Such serial observations on this disease are considered unique. Differential diagnosis and the clinical manifestations are discussed.

BY WILLIAM R. AUSTAD, M.D.
GEORGE R. THOMPSON, M.D.
RAMON R. JOSEPH, M.D.
ALL FROM ELOISE

While the occurrence of polyarthritis with ulcerative colitis is well recognized, the association with regional enteritis is less common. It is thought to be analogous to the arthritis occurring with ulcerative colitis or Whipple's disease[1]. However, there are considerably fewer descriptions of the arthritis of regional enteritis in the literature, and only three cases have previously been described in which the arthritis preceded the occurrence of bowel disease[2,3,4].

There is only one report of the synovial fluid characteristics and histologic changes in the synovial membrane occurring with regional enteritis[5] and in these cases the tissue was obtained nine and thirteen years after the onset of arthritis.

We have cared for a young Negro girl who initially presented with migratory polyarthritis, subsequently developed erythema nodosum, and finally exhibited the characteristic gastrointestinal manifestations of regional enteritis. Early in her course synovial fluid and synovial biopsy studies were obtained, and these were repeated two years after the onset of her disease, as were serologic tests for the rheumatoid and antinuclear factors. We feel it important to draw attention to these findings as, to our knowledge, this is the first time such serial observations have been available. We also wish to emphasize the need to consider regional enteritis as an unusual association with acute polyarthritis.

Case Report

R.H. (WCGH No. 327506), a Negro female, was first hospitalized in February 1965 at the age of 15 years on the pediatric surgical service with a three-day history of lower abdominal pain and nausea. As the pain subsequently was localized to the right lower quadrant of the abdomen and was accompanied by guarding and rebound tenderness, a diagnosis of acute appendicitis was made. Laboratory studies showed a white blood cell count of 8,600 cells per cubic millimeter, hematocrit of 33%, and 2-3+ proteinuria. A quantitative Kline cardiolipin test was reactive at 1:1 dilution, but the Reiter protein complement fixation test was negative. A laparotomy was performed, with removal of an inflamed appendix, interpreted histologically as chronic periappendiceal inflammation.

The patient was then asymptomatic until April 1965, when she developed intermittent attacks of arthralgia and arthritis. She was hospitalized for the second time in June 1965 with acute pain, swelling, erythema, and tenderness of the ankles and knees. During the interval of time she had lost 20 pounds. She had no abnormal bowel symptoms, and other than the evident arthritis, physical examination was unremarkable. Laboratory studies showed a white blood cell count of 8,300 cells per cubic millimeter, with a normal differential. The hematocrit was 32%, with evidence of iron deficiency (serum iron 18 mcg./100 ml., iron binding capacity 345 mcg./100 ml. with a saturation of 5.2%). The urine was normal except for a trace of protein. Serum uric acid was 4.2 mg./100 ml. The total serum protein was 7.4 gm./100 ml., with electrophoretic separation showing 3.2 gm./100 ml., albumin; 0.36 gm./100 ml. alpha I; 0.81 gm./100 ml. alpha II; 1.07 gm./100 ml. beta; and 1.96 gm./100 ml. gamma globulin. Serological studies revealed a weakly reactive Hyland slide test for the rheumatoid factor; an antistreptolysin-0 titer of 125 Todd units; a non-reactive Kline cardiolipin test; and a negative test for the C-reactive protein. The Wintrobe sedimentation rate was 55 mm./hr., and two L.E. cell preparations were negative. X-rays of the knees and ankles were normal, as was an electrocardiogram. Synovial fluid aspirated from the right knee showed 525 red and 12,300 white blood cells per cubic millimeter (90% polymorphonuclear and 10% mononuclear leukocytes). A good mucin clot was formed on addition of acetic acid. Cultures of the synovial fluid were negative. A diagnosis of possible rheumatoid arthritis was made and the patient was discharged on aspirin and ferrous sulfate.

The third hospital admission occurred in July 1965, because of persistent ankle pain and swelling. Two weeks prior to admission she had noted the onset of red, tender nodules on the skin of her lower legs. She also had developed abdominal pain, worse at night, and relieved by food, antacids, and reduction of her aspirin dosage. Physical examination revealed a further weight loss of 10 pounds. The ankles were swollen, warm, and tender, as subsequently were the knees. Several tender erythematous nodular lesions, typical of the appearance of erythema nodosum, were present on her lower legs.

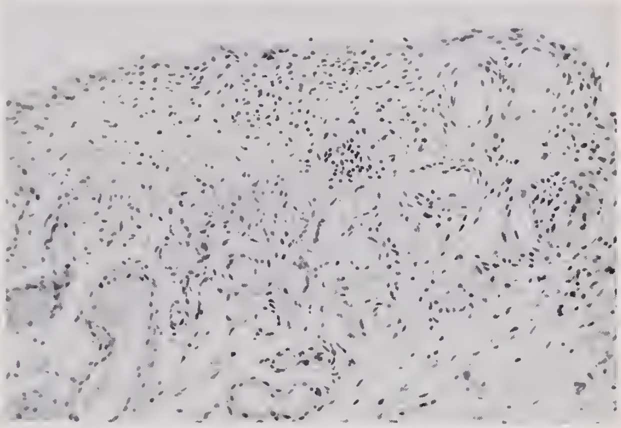
Figure 1: Biopsy of synovium of right knee, July 1965. Note the marked vascularity, some leukocytic infiltration, and fibrinous exudate overlying the synovium (210 X, H.&E.).

STUDIES CARRIED OUT during this hospitalization included a white blood cell count of 9,850, and hematocrit of 30%. Serum iron was again low (13 mcg./100 ml.), and blood loss was suspected. However, several stool examinations were negative for occult blood, and upper gastrointestinal X-ray series were normal. Hemoglobin electrophoresis showed AA hemoglobin. Serum calcium, phosphorus and uric acid were normal. Serum protein electrophoresis was similar to that of June 1965. Wintrobe sedimentation rate was 52 mm/hr. Serologic tests showed a 4+ C-reactive protein; non-reactive Kline cardiolipin test, and a weakly reactive Hyland slide test for the rheumatoid factor. L.E. cell preparations were negative, but a fluorescent antibody test for antinuclear factors was positive[6]. X-rays of the chest, knees, and ankles were normal.

Biopsy of one of the nodules on her lower right leg showed leukocytic infiltration and perivasculitis, changes consistent with erythema nodosum. Tuberculin skin test was negative. Because of the possibility of sarcoidosis, a percutaneous liver biopsy was performed. The specimen showed only a slight increase of chronic inflammatory cells in the portal area, interpreted as being a nonspecific change. The right knee joint was aspirated and a needle biopsy was performed, using a Cope needle. The synovial fluid contained 7,000 red and 5,300 white blood cells per cubic millimeter, of which 60% were polymorphonuclear leukocytes and 40% mononuclear cells. There was a good mucin clot on addition of acetic acid, and cultures were again negative. Synovial tissue showed increased vascularity (Fig. 1), an overlying fibrinous exudate, and in other areas synovial cell hyperplasia and inflammatory cellular infiltration. This was interpreted as a chronic, non-specific synovitis. It was thought she had a connective tissue disease, probably systemic lupus erythematosus, and an iron

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deficiency anemia secondary to blood loss related to salicylate therapy, and poor dietary habits. She was discharged on salicylates, antacids, and ferrous sulfate.

SHE WAS SHORTLY readmitted (for the fourth time) in September, 1965, because of nausea, vomiting and abdominal pain. The pain was described as being knife-like and colicky in character, primarily in the periumbilical area with radiation into the right lower quadrant. The pain was unrelated to and unrelieved by food or antacids; would spontaneously subside after 15-20 minutes, only to recur. Physical examination revealed abdominal tenderness and moderate rebound tenderness with an ill-defined mass palpable in the right lower quadrant. There was an anal fistula present discharging purulent material. The ankles and knees were warm, swollen and tender, and there were erythema nodosum lesions on her lower legs.

Laboratory studies showed 9,950 white blood cells per cubic millimeter (69% polymorphonuclears), hematocrit of 30%, and a negative Kline cardiolipin test. A repeat fluorescent antibody test for antinuclear factors was now negative. Stool examination was positive for blood. Proctosigmoidoscopy revealed a perianal abscess with a fistula-in-ano, but no colonic abnormalities. Barium enema X-ray was normal, but there was non-filling of the terminal ileum. An upper gastrointestinal examination with small bowel studies showed a normal stomach and duodenum, but narrowing of the lumen, fistula formation, and "a string sign" in the terminal ileum (Fig. 2). These findings were interpreted as being diagnostic of regional enteritis.

The patient was treated with antispasmodic drugs and antibiotics. Because of unresponsiveness to medical therapy a laparotomy was performed revealing thickened, edematous terminal ileum with firmly adherent loops of adjacent ileum. The cecum and colon were normal. The diseased bowel was resected and an end-to-end ileocolostomy performed. The resected specimen contained several intestinal fistulous tracts and microscopically showed a severe acute and chronic ulcerative inflammatory process involving the mucosa, submucosa and focally extending through all muscle layers into the serosa. The process was also marked by extensive edema and vascular granulation tissue. These findings were considered consistent with the diagnosis of regional enteritis.

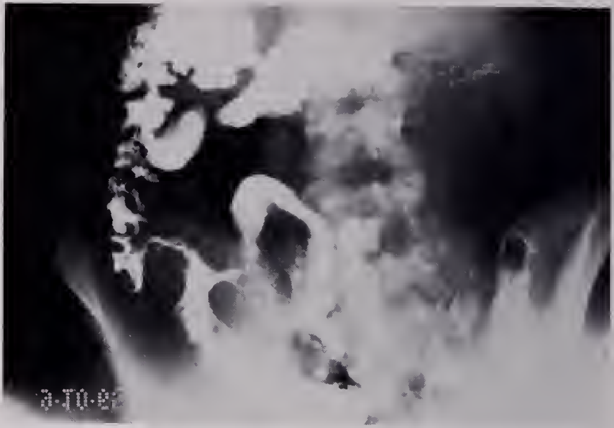

Figure 2: Small bowel X-ray, September 1965. Note narrowed lumen with "string sign," and fistula formation in terminal ileum, typical of regional enteritis.

POSTOPERATIVELY THE PATIENT did very well and by the fifth postoperative day the arthritis and skin lesions (erythema nodosum) had markedly diminished. The anal fistula healed spontaneously, and she was discharged much improved.

During the subsequent 18 months she has continued to do well. The skin lesions of erythema nodosum have not recurred. With dietary indiscretions she has noted the occurrence of diarrhea, with up to seven stools per day, lasting only two-three days, and clearing spontaneously with resumption of a normal diet. She has also had occasional attacks of arthritis in the knees and ankles, lasting one-two days, always responding to salicylate therapy. She has attended high school, and has lived a normal life.

In April 1967 she was admitted for the fifth time because of acute arthritis in both ankles and the left knee. Two weeks prior to admission she had developed gastroenteritis, with fever, nausea, vomiting, and diarrhea (seven loose stools per day). Subsequently arthritis developed. The fever, nausea, vomiting, and diarrhea cleared shortly. However, the arthritis persisted, necessitating hospitalization. Examination showed the ankles to be

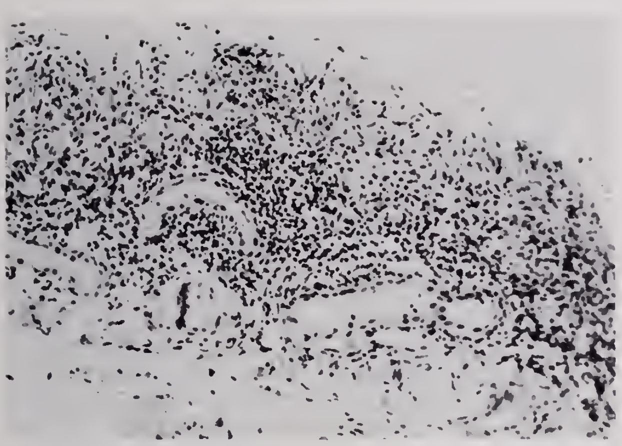

Figure 3: Biopsy of synovium, left knee, April 1967. Note marked inflammatory infiltration, with synovial hyperplasia. This is interpreted as a chronic active synovitis (280 X, H.&E.).

warm, swollen, red and very tender. The left knee was swollen and tender. The abdomen was soft and non-tender. Laboratory studies revealed a white blood cell count of 7,750 cells per cubic millimeter hematocrit 34.5%. The Wintrobe sedimentation rate was 52 and 57 mm./hr. on two occasions, and the test for the C-reactive protein was 4+ positive. L.E. cell preparations were negative, as was a fluorescent antibody test for antinuclear factors. A Hyland slide test for the rheumatoid factor was weakly reactive. Total serum proteins were 7.1 gm./100 ml., with 2.6 gm./100 ml. albumin; 0.31 gm./100 ml. alpha I; 0.77 gm./100 ml. alpha II; 1.08 gm./100 ml. beta; and 2.34 gm./100 ml. gamma globulin. X-rays of the chest, knees and ankles were normal, and an upper gastrointestinal X-ray series with small bowel detail studies revealed no evidence of recurrent ileitis. The left knee joint was aspirated, and a synovial biopsy performed with the Cope needle. Synovial fluid contained 400 red blood cells, and 10,000 white blood cells (93% polymorphonuclear and 7% mononuclear leukocytes) per cubic millimeter. Addition of acetic acid gave a good mucin clot. Synovial tissue (Fig. 3) showed an active, chronic, productive synovitis. The patient was treated with rest, salicylates, and a short course of phenylbutazone, with complete clearing of her arthritis. She was discharged asymptomatic ten days after admission.

Discussion

It is quite possible that the first symptoms of regional enteritis in this girl were those resembling appendicitis in February 1965. Supporting this would be the biologic false positive test for syphilis (positive Kline, negative Reiter's protein complement fixation test), which subsequently became negative. Somewhat against this are the absence of findings suggestive of regional enteritis at appendectomy and her rapid and complete recovery after surgery. However, regional enteritis involving the cecum and the base of the appendix has been indicted as causing appendicitis with no other findings at laparotomy.[7]

The diagnosis of regional enteritis was established in this patient by characteristic radiologic changes in the small bowel. (Fig. 2) The negative proctosigmoidoscopy and the negative colon examination made ulcerative colitis unlikely. The radiologic findings were confirmed at laparotomy, and the histologic changes in the resected small bowel were those of regional enteritis. The possibility of the patient also having systemic lupus erythematosus exists. However the abscence of renal disease and evidence of serositis during a period over two years is against this diagnosis.

Table 1 summarizes the laboratory data over 26 months of observation. Of particular interest is the transiently positive test for the antinuclear factor. This test was repeated testing the serum of July and September 1965 together in the same run, with again a positive test with the July and negative test with the September serum, making a laboratory error an unlikely explanation. Also of interest is the development of the C-reactive protein in her serum between June and July 1965, and its presence in April 1967, despite relatively mild symptoms in the interim. This is thought to be indicative of continuing activity of the disease process. Supporting this is the fall in serum albumin and rise in gamma globulin between 1965 and 1967. However, there was no radiologic evidence of bowel disease in 1967.

IN PREVIOUS STUDIES of peripheral arthritis associated with regional enteritis, specific serologic tests have been infrequently reported.[2,3,4,5,7,8,9] Biologic false positive test for syphilis

Table 1. Summary of serological and synovial fluid studies during the 26 months patient was followed.

Date	2/65	6/65	7/65	9/65	4/67
Rheumatoid Factor	—	Weakly Reactive	Weakly Reactive	—	Weakly Reactive
S.T.S.*	+1:1	Neg.	Neg.	Neg.	Neg.
L.E. Cell Test	—	Neg.	Neg.	—	Neg.
Antinuclear Factor	—	—	+	Neg.	Neg.
C-Reactive Protein	—	Neg.	4+	—	4+
Serum Albumin	—	3.2 g.	3.24 g.	—	2.6 g.
Serum Gamma Globulin	—	1.96 g.	1.95 g.	—	2.34 g.
Synovial Fluid					
W.B.C.	—	12,300	5,300	—	10,000
% PMNs	—	90	60	—	93
Mucin Clot	—	Good	Good	—	Good

*Serologic Test for Syphilis

has not been previously observed, and tests for antinuclear factors have been negative.[4,10] Tests for the rheumatoid factor have also been negative except when classical rheumatoid arthritis has preceded the occurrence of regional enteritis.[3,4]

Synovial fluid changes were essentially similar in 1965 and 1967. However, the synovial membrane histologically showed an increase in inflammatory cellular infiltration and synovial proliferation in 1967 compared to 1965 (Figs. 1 & 3). While the sampling error is admittedly great with blind needle biopsy, these changes were thought suggestive of progression of the synovial lesion. These histologic changes are similar to those previously described[5], and may be characterized as a chronic, active, synovitis. The synovial fluid findings of a predominantly polymorphonuclear pleocytosis with a good mucin clot test are similar to those reported with ulcerative colitis.[11] Soren, however, found a lesser pleocytosis, predominantly lymphocytic, in his cases of arthritis with regional enteritis.[5]

The occurrence of arthritis with regional enteritis has been reported to vary from 2.5% to 6.5%,[4,7,8,9,10] giving a mean incidence of 3.8%. The incidence of arthritis with ulcerative colitis has been accepted as 4 to 8% though the trend is toward higher estimates with reports of 15 to 20% cited.[3] Erythema nodosum has been reported to occur in 0.83 to 2.1% (mean 1.09%) of patients with regional enteritis,[4,7,8,9] 2.88% of patients with ulcerative colitis[3] and 9.5% of patients with systemic lupus erythematosus.[12] It is listed as an exclusion in the American Rheumatism Association's criteria for the diagnosis of rheumatoid arthritis.[13]

IT IS OUR OPINION that our patient presented several manifestations that may be related to a hypersensitivity type of reaction, i.e., erythema nodosum, transiently positive tests for syphilis, antinuclear factors, and the rheumatoid factor. It is interesting to speculate on the relationship of hypersensitivity to her arthritis and enteritis. In any event, it is well to emphasize that regional enteritis may be an unusual cause of migratory polyarthritis. Earlier small bowel detail X-ray studies might have led to the correct diagnosis of regional enteritis sooner in our patient.

Summary

The case of a 15-year-old Negro girl who presented with acute peripheral arthritis seven months before the development of classical regional enteritis is described. The diagnosis of regional enteritis was established by typical roentgenologic changes in the small bowel, with fistula formation, and a normal colon. These findings were confirmed at laparotomy. The arthritis was associated with erythema nodosum, an elevated sedimentation rate, a transient biological false positive test for syphilis, and the presence of rheumatoid and antinuclear factors in the blood. Synovial fluid examination revealed leukocytosis, predominately polymorphonuclear; and a good mucin clot with the addition of acetic acid. His-

tologic changes in the synovial membrane were compatible with a chronic, active nonspecific synovitis. Follow-up studies two years later are presented.

This is the first time to our knowledge that such serial observations of the arthritis occurring with regional enteritis have been available. This case further illustrates the diagnostic dilemma presented by a patient with atypical, acute, peripheral arthritis.

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Chlorpromazine and Thioridazine In Severe Mental Deficiency

ABSTRACT: A comparative study of chlorpromazine (Thorazine) and thioridazine (Melloril) in the treatment of behavior disorders in mental retardates is reported. Global evaluation and change in target symptoms showed thioridazine to be more effective. The increased benefit derived from thioridazine was attributed in part to a greater toleration, notably a reduced incidence of drowsiness, ataxia and Parkinsonism.

BY EROL UCER, M.D.
LAPEER

The effectiveness of the phenothiazines in the treatment of mental disorders, notably schizophrenia[1,2,3] is well-established. Less well-recognized is their apparent usefulness in the treatment of behavior disorders, especially those associated with mental retardation.[4,5,6]

The drugs most widely used for this purpose at this hospital* have been chlorpromazine (Thorazine and thioridazine (Mellaril), each of which has had its adherents among the members of our staff. The comparative study reported here was undertaken in an effort to determine any differences between these two phenothiazines in the management of behavior disorders associated with mental retardation.

Methods and Materials

Eighty extremely retarded female patients who were in satisfactory physical condition were divided into two groups of 40 patients each, one to receive thioridazine, the other chlorpromazine. Patients ranged in age from 15 to 47 years, median age for the patients receiving thioridazine was 28 years, while the median age for those receiving chlorpromazine was 26 years. All of the patients were either congenitally retarded or had experienced birth trauma or postnatal complications and had a low degree of intellectual function. Sixty-four patients had IQ's less than 25 (profoundly retarded) while the IQ's of the remaining 16 patients ranged from 25 to 29 (severely retarded).

All behavioral medications were withdrawn during the two weeks prior to the study in order to establish a base line of behavior. During this period, nursing personnel recorded frequency and severity of seizures, need for restraints and the severity of the target symptoms. Aggressiveness, hyperkinesia, withdrawal, self-abuse, assaultiveness and temper tantrums were rated on a scale from 0-absent to 4-severe and these were entered on a chart devised for this study, as were the observations of the author who saw each patient at least once weekly.

At the conclusion of the period with no medication, patients were placed on one or the other of the study drugs. The starting dose was individualized for each patient, ranging from 25 mg. to 150 mg. thioridazine or chlorpromazine per day depending on the severity of the patient's symptoms and extrapolation of the dose of medication she had received prior to the study. The liquid forms were used, with dosage being adjusted as required for optimum control. The median dose for both drugs was 150 mg. per day; the maximum dose for thioridazine was 800 mg. per day (reached in 3 patients) and 600 mg. per day for chlorpromazine (reached in 2 patients).

Ratings for each patient were repeated weekly during the 8-week study. The severity of symptoms before and after treatment, the patient's general attitude and adjustment, her ability to partake in and cooperate with ward activities, the impressions of the attendants and medical staff and assessment of side effects formed the basis for a global evaluation of each patient at the conclusion of the study.

Results

The effect of the drugs on the six target symptoms at 2 weeks of treatment, 4 weeks of treatment and 8 weeks of treatment is shown in Table I, which shows that all target symptoms responded to treatment with the drugs, five of the six significantly so. Improvement with thioridazine appeared to be both more rapid and more intense

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Table I
Average Improvement In Target Symptoms

Symptom	Drug	Week 2	Week 4	Week 8
Aggressiveness	Chlorpromazine	−0.023	0.071	0.324*
	Thioridazine	0.478*	0.465*	0.844*
Hyperkinesia	Chlorpromazine	0	0.321	0.304*
	Thioridazine	0.283*	0.328*	0.609*
Withdrawal	Chlorpromazine	0.182*	0.286*	0.217
	Thioridazine	0.261	0.259*	0.484*
Self-abuse	Chlorpromazine	0.046	0.214	0.130
	Thioridazine	0.087	0.034	0.141
Assaultiveness	Chlorpromazine	0.091	0.143	0.500*
	Thioridazine	0.609*	0.793*	1.109*
Temper Tantrums	Chlorpromazine	0.227	0.286	0.696*
	Thioridazine	0.456*	0.517*	0.969*

* denotes significant improvement over base line rating (probability value less than 0.05)
minus sign indicates worsening

The following between drug differences in improvement were significant (probability value less than 0.05):

Thioridazine superior to chlorpromazine:

Aggressiveness at weeks 2 and 8

Assaultiveness at weeks 2, 4 and 8

than with chlorpromazine. Thioridazine reduced aggressiveness, hyperkinesia, assaultiveness and temper tantrums for each of the periods, whereas chlorpromazine did not produce significant improvement in these symptoms until week 8.

Chlorpromazine produced a more rapid improvement in the target symptom of withdrawal, but this was not sustained. Thioridazine did not bring about significant improvement of withdrawal until week 4. Thereafter, the effect of the drug on this symptom became more pronounced, reaching its peak at the end of eight weeks.

Over and above these comparisons of each drug with its pre-drug levels, between-drug comparisons showed that thioridazine was more effective than chlorpromazine in the lessening of aggressiveness and assaultiveness.

The results of the global evaluation made at the conclusion of the 8-week study are shown in Table II, which excludes 5 patients dropped from the study because of intercurrent illness. Sixteen (57%) of the 28 profoundly retarded patients receiving thioridazine were considered improved, 9 (32%) unchanged and 3 (11%) worse. Fourteen (44%) of the 32 profoundly retarded patients recieving chlorpromazine were considered improved, an equal number unchanged and 4 (12%) worse. Among the severely retarded patients, 4 of the six receiving chlorpromazine showed improvement, as did 7 of the 9 on thioridazine.

Further evidence of the relative effectiveness of the two drugs was shown in the lessened need for restraints in both groups, 53% reduction in those receiving thioridazine and 10% reduction in those receiving chlorpromazine. This may be related to the alleviation of aggressiveness and assaultiveness.

Fifteen patients had a previous history of seizures and of these, 12 were treated with thioridazine and 3 with chlorpromazine. The incidence was low in all but two patients, both of whom received thioridazine and exhibited a reduction of seizure activity during the study. No patients experienced an increase in seizures.

Side effects were generally mild and self-limiting. Drowsiness of a mild degree was noted in one-third of the patients receiving thioridazine and in one-half of the patients on chlorpromazine (Table III). Ataxia and parkinsonism were somewhat

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Table II
Global Evaluation

Drug	Profoundly Retarded				Severely Retarded				Totals			
	No.	Improved	No Change	Worse	No.	Improved	No Change	Worse	No.	Improved	No Change	Worse
Chlorpromazine	32	14 [44%]	14 [44%]	4 [12%]	6	4 [66%]	1 [17%]	1 [17%]	38	18 [47%]	15 [40%]	5 [13%]
Thioridazine	28	16 [57%]	9 [32%]	3 [11%]	9	7 [78%]	1 [11%]	1 [11%]	37	23 [62%]	10 [27%]	4 [11%]

Table III
Side Effects

	Thioridazine	Chlorpromazine
Drowsiness	13	18
Hypoactivity	1	0
Ataxia	1	12
Insomnia	1	0
Muscular Weakness	1	0
Emesis	3	1
Dystonia	0	1
Dryness of mouth	0	2
Parkinsonism	0	6
Salivation, Drooling	0	2
Fatigue	0	1

troublesome with chlorpromazine. Moderately severe vomiting developed in four patients (3 thioridazine, 1 chlorpromazine) after two weeks of treatment. A change of dosage form, i.e., from liquid to tablets, caused disappearance of all gastrointestinal symptoms within 3 days. No physical cause for this condition was found on physical and X-ray examination.

Discussion

Both chlorpromazine and thioridazine proved to be of value in improving the behavior disorders in these retarded patients. This finding is in line with that of Badham, et al.[7] who described thioridazine as "effective in controlling disorders of behavior in a significant proportion of severely subnormal patients." In the study reported here, thioridazine was more effective than chlorpromazine in the extent of reduction of target symptoms and number of patients improved. In part, this may be the result of the better toleration for larger doses of thioridazine where required, as indicated by the fewer side effects it generated.

A concomitant result of the improvement obtained in this study was the improved order in the wards where the patients were housed. Patients seemed happier in their surroundings and there were fewer accidents, probably as a result of the reduced hyperkinesia and assaultiveness of the patients. This parallels the experience reported by Abbott et al.[8] who found that thioridazine's effect on more fractious patients led to a more reassured attitude in their cohorts.

Summary

A comparative study of chlorpromazine and thioridazine showed both drugs to be effective for the treatment of behavior disorders in mental retardates, as measured by improvement in target symptoms and a global evaluation. Thioridazine exerted a more rapid and intense effect on aggressiveness, assaultiveness, hyperkinesia and temper tantrums than did chlorpromazine. The increased benefit derived from thioridazine was attributable in part to a greater toleration, notably the reduced incidence of drowsiness, ataxia and Parkinsonism.

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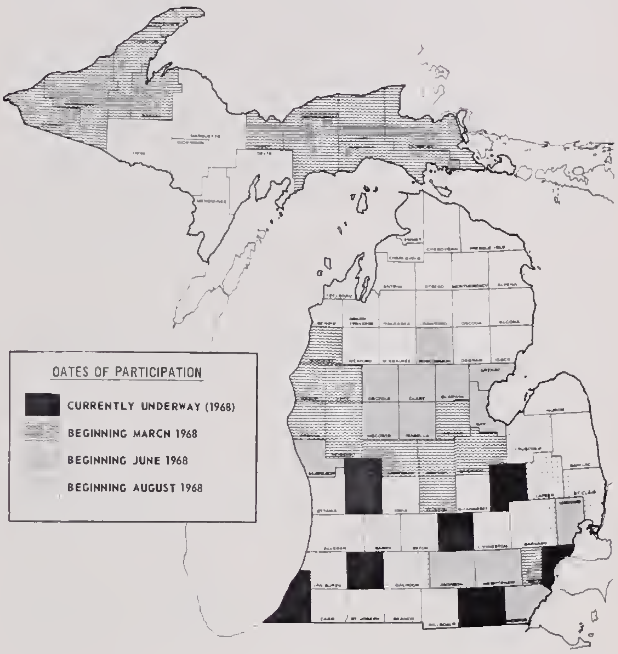
Progress Report on Project ECHO, Michigan's Continuous Health Survey

Editor's Comment: Many of the readers of MICHIGAN MEDICINE have had little opportunity to gain any knowledge of one type of government health program called Project ECHO. The authors of this article outline its purposes and explain the initial steps to attain those that have been taken in a Michigan area.—George H. Lowrey, M.D., Scientific Editor.

BY MAURICE S. REIZEN, M.D.
ROBERT F. LEWIS, PH.D.,
BOTH OF LANSING

HEALTH JURISDICTIONS TO PARTICIPATE IN PROJECT ECHO



Health is related to the way people live and to their surroundings. A program geared to improve the health of a people must, therefore, attempt to evaluate the prevailing ecological conditions and armed with this knowledge formulate changes for the better. Changes by neighborhood seems to be the approach most likely to succeed. By focusing on specific and current health problems, one can communicate with the residents and provide for cooperative program development involving local citizenry, governmental agencies at all levels, plus interested professional and voluntary organizations.

Project *ECHO* (Evidence for Community Health Organization) is designed to provide the foundation for such an approach and is specifically directed to community and neighborhood comprehensive health planning; ie. the relating of programs to documented needs and the marshaling of resources to meet these needs.

On the national scene, the direction and progress of health programs has been supported by information contributed by the U.S. Census and the National Center for Health Statistics. Consisting of interviews and medical examinations, appraisals of health facilities and services, evaluation of environmental conditions, etc., a series of reports has evolved giving an accurate profile of many aspects of the health of the nation, viz: The National Health Survey. However, national statistics have little relevance for an individual state or community, much less a neighborhood. And, to paraphrase the Folsom Report, "Health is a Neighborhood Affair."[1]

PROJECT ECHO WAS conceived in January, 1967, in an effort to determine whether a continuous health survey would be of value in providing answers to a multitude of questions. These queries were leveled at the Michigan Department of Public Health as well as local, state and national organizations, both within and without the framework of government.

The mechanics of this project take place at the local level. The collection, dissemination and utilization of information is the function of the local health department. Data is collected by local professionals — environmental specialists and public health nurses working in teams. This will give them first-hand knowledge of conditions within their community, thus enabling them to effectively communicate this intelligence to citizens and governmental leaders.

The function of the Michigan Department of

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[1] *Health Is a Community Affair*, National Commission on Community Health Services, Harvard University Press, Cambridge, Mass., 1966

Public Health in Project ECHO is to render technical service to local health workers. Thus, the Center for Health Statistics of the Michigan Department of Public Health makes available scarce professional expertise for local development, coordinated direction and objective interpretation of results. The Center provides statistical and computing services; provides technical and professional guidance in data collection and dissemination; processes and summarizes data; and maintains a single protocol of methodology by means of training and retraining of personnel in many local health agencies.

Many other divisions of the Michigan Department of Public Health also contribute their specialized services as required.

PROJECT ECHO WAS launched in 1967 for the following cities and counties: Benton Harbor, Kalamazoo, Grand Rapids, Lansing, Genesee County, Adrian and Detroit.

The map shows the other counties and areas that are scheduled to join the program in March, June and August of 1968.

Phases Involved in Project Echo

I. Environmental block appraisal, block mapping and block identification.

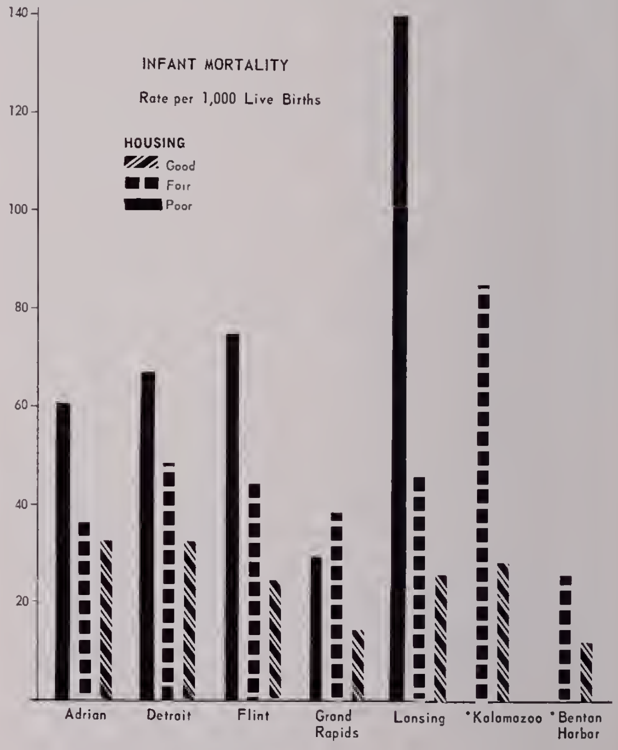
Project ECHO starts with a mapping phase whereby blocks are identified and form the basic reference filing system for all future data. Census tracts provide a useful framework, but are not necessarily the only method of designating a sample area. School boundaries, natural boundaries, and neighborhood areas may also be used. Work starts with a base of approximately 250 blocks, spanning areas both of degradation and relatively high quality. Each block is observed and a record made as to the quality of housing. A modification of the American Public Health Association method for evaluating the housing is used.[2, 3]

Each dwelling unit within the block is checked on the initial survey. The list of these units provides the basis for the sampling techniques to be used on subsequent visits. Population estimates can be made later which will lead to current estimates far more accurate than interpolation of outmoded census data.

The results of the external environmental appraisal of blocks is mapped and color-coded on the basis of good, fair, and deteriorated areas and forms the foundation for presentation of other data so that the relationship between geography, health indices and quality of environment can be delineated. Once completed, block reappraisal will be kept current by return surveys. The bar graph depicting infant mortality is based on information obtained from the pilot area in each community; and may change when more blocks are surveyed.

II. Health appraisal based on individual interviews with continuing probability sampling, together with an updating of dwelling unit listing and environmental changes.

Phase 2 involves obtaining specific health status information from *selected* households. From the listing of dwelling units obtained from Phase 1,



* Data obtained in Kalamazoo and Benton Harbor was insufficient in the poor-housing classification.

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2. *An Appraisal Method for Measuring the Quality of Housing*, Am. Public Health Assoc., Committee on The Hygiene of Housing, 1790 Broadway, 1945. New York, N.Y.
3. Waldrop, Reuel H., *Community Block Survey and Socioeconomic Stratification*, U.S.P.H.S. National Communicable Disease Center, Atlanta, Georgia, no date published.

the Center for Health Statistics provides to each jurisdiction a weekly sample of dwelling units. Three enquiries are made to each dwelling unit over a three-week period. in the first visit, the sanitarian reobserves the block for environmental changes, updates the listing of dwelling units, and also makes an appraisal of the interior. The nurse initiates a health interview which covers relatively superficially the family characteristics, chronic medical disorders and recent illnesses. The second and third visits are frequently conducted by telephone. Here, questions are asked concerning health situations, use of health services, additional recent illnesses and immunization status. It might be in order at this point to inform the reader that the confidentiality of this material is never broached and this is emphasized to the interviewees. As a result, the reception has been excellent to date.

The interview is intended to provide basic information on demographic characteristics, morbidity and use of health services, with intensive *local* inquiries to be handled as a special section, but using the ECHO sampling base. Information such as this is not available through any other means at present.

III. Dissemination of information to citizens, and local and state health agencies.

Phase 3 involves feeding the information back to the community. Here, the Center for Health Statistics will be responsible for processing, analyzing, and summarizing the information accumulated on a block-by-block basis. The material produced will be in response to what the nurse, sanitarian and local health officer request. Areas of concern are identified and the material may be presented via several different vehicles. Overhead projections, 35mm slides, spot maps, tables, etc., all have been used in one locale or another.

An additional dividend from the Center is the timely availability of statistical information previously stored but rarely utilized. Thus, spot maps have been produced on short notice noting the location by block of each case of tuberculosis, syphilis, neonatal mortality, deaths from heart, cancer, stroke, etc., for the use of concerned health departments and others.

IV. Neighborhood Action Programs.

From the local aspect here is where ECHO survives or goes by the wayside. The responsibility is squarely up to the local health agency. It may and should involve other units of government, lay and volunteer groups, but most vital to its success are the residents of the neighborhood itself. There is a significant aspect of ECHO apart from action programs and this is in the long term evaluation of the multiple problems that beset any community whether it involves solely the health department or not.

EXPERIENCE IN MICHIGAN and elsewhere has shown that neighborhood people are willing to put time and effort into appropriate health activities given the information and the motivation. Rat control, immunization procedures, baby clinics, infant mortality surveys, earlier prenatal care for the medically deprived are but a few of the issues in which a neighborhood can undertake action programs when given the proper stimulus.

At the present time, Ingham County is involved in all of the first three phases of Project ECHO. By the time this article goes to press, Phase IV will be underway. Presentation of the above material in detail has already been scheduled for

REIZEN

CO-AUTHORS

Doctor Reizen is Director of the Ingham County Health Department. Doctor Lewis is Chief, Michigan Center for Health Statistics, Michigan Department of Public Health, Lansing.

The Michigan ECHO project is supported in part by funds from the U. S. Public Health Service, Comprehensive Health Planning, P.L. 89-749.

LEWIS

interested church groups, governmental units, medical students, and neighborhood organizations.

Contemplated Long-term Results for Project ECHO

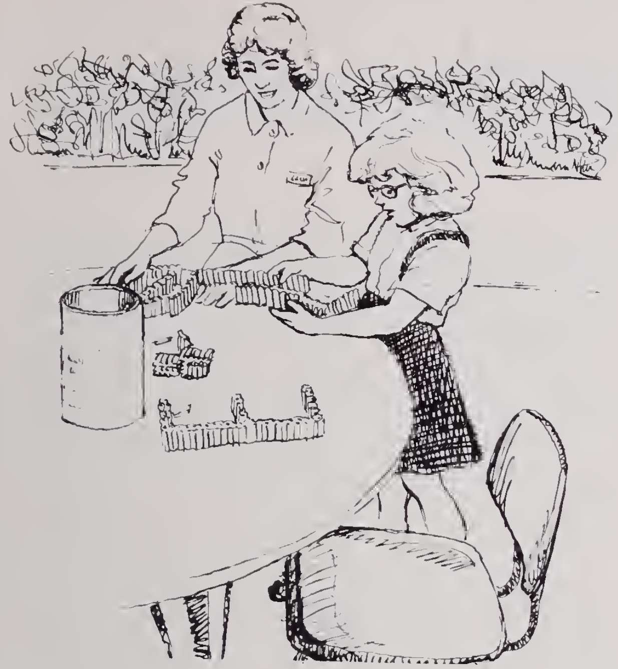
1. Current population estimates for any configuration of small areas at any time.
2. Current information about the health and the physical environment of the people of Michigan at any time or over any period of time.
3. Identification of the ways of life and the elements in the physical and social environment which appear to lead not only to illness, but to "well-ness," or to a positive state of health.
4. Identification of neighborhoods in which something can be done with present resources and a description of their characteristics which can lead to action programs precisely tailored to specific problems, including budgeting, timing, methods of organization and operation, duration, and anticipated results.
5. Positive evidence for the initiation of new programs and a reappraisal of existing programs for the various agencies involved in alleviating observed health problems.
6. Identification of geographic areas before they become extreme problems, as a guide to long range planning.
7. Observation of the rate of change in items of specific concern as a means of evaluating levels and types of programs.
8. Provision of vital statistics for individual localities in a way which is immediately useful for program operation.

Relevance To Practicing Physicians

The technique of Project ECHO has usefulness readily apparent to practicing physicians. Phase II, in particular can present information to the physician which has never been made available before, especially at the local level.

We will be able to furnish our colleagues with accurate information as to the immunization status of the area, the number of "miscarriages" that really occur in a year, the delivery of health services by whom and where located, etc. Other questions may be inserted into this viable survey and removed when no longer required. A separate section in the questionnaire has been provided for topics of local concern. These may very well be requested by the local medical society.

The majority of physicians we encounter have the subjective opinion that most of the people in their neighborhood are receiving good medical care. We strongly agree with this premise. Here is an opportunity to present evidence that the bulk of our population is truly receiving competent health services in Michigan. Item 3 under contemplated long-term results would also be of ultimate value to physicians. This is the identification of the positive factors in the "well-ness" of the population surveyed. What are the plus factors evident in our neighborhoods and how can they be transplanted to less healthy areas?



A rooftop patio for pediatric patients at the University Hospital at Ann Arbor was featured in the July issue of THE AUXILIARY LEADER, the journal for hospital auxiliaries. Made possible by the interest and contributions of a number of Michigan businessmen, the rooftop garden was formerly a drab concrete playcourt. Now it serves as a place for play and even outdoor picnics for the hospitalized children. It is furnished with flowers, trees, and shrubbery, and is manned by volunteers and hospital teachers who instruct and supervise the children in their games and schoolwork.

BOOKS RECEIVED BY MSMS

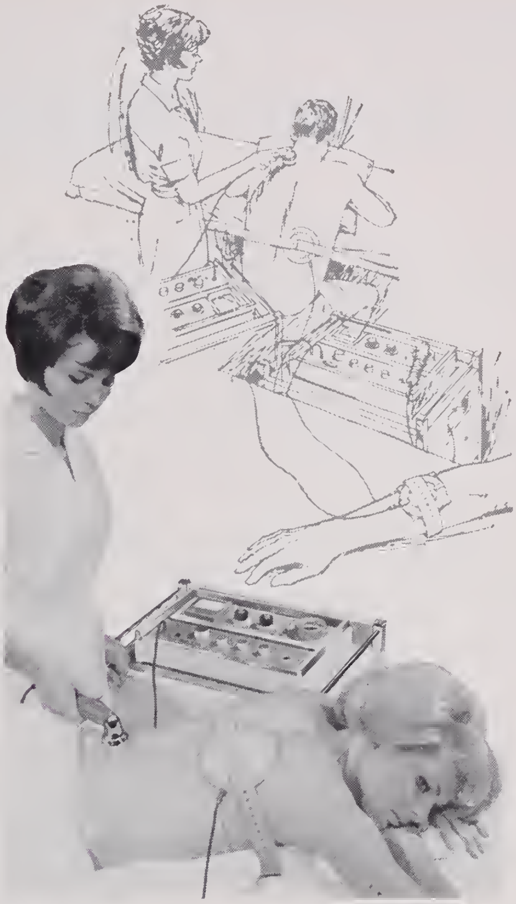
The Human Adrenal Cortex: its Function Throughout Life. (Ciba Foundation Study Group No. 27) Edited by G. E. W. Wolstenholme and Ruth Porter. 146 pp, illustrated. Little, Brown and Company, Boston, 1967.

Antilymphocytic Serum. (Ciba Foundation Study Group No. 29) Edited by G. E. W. Wolstenholme and Maeve O'Connor. 165 pp, illustrated. Little, Brown and Company, Boston, 1967.

Drug Responses in Man. (Ciba Foundation Symposium) Edited by G. E. W. Wolstenholme and Ruth Porter. 257 pp, illustrated. $13.00. Little, Brown and Company, Boston, 1967.

Myotatic, Kinesthetic and Vestibular Mechanisms. (Ciba Foundation Symposium) Edited by A. V. S. deReuck and Julie Knight. 331 pp, illustrated. $13.50. Little, Brown and Company, Boston, 1967.

Burns, Shock, and Plasma Volume Regulation. By Carl A. Moyer and Harvey R. Butcher, Jr. 428 pp, illustrated. $18.50. C. V. Mosby Company, Saint Louis, 1967.



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What Is Current Thrust of MSMS In Economics, Organization, MD Business Problems?

Where does MSMS stand regarding economics, organization, and business problems of private practice?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November issue of *Michigan Medicine,* on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter VI in the booklet.

Discussion

Environment of Practice

A full-fledged effort by MSMS is being conducted to attempt to gain some insight into the future environment in which medicine will be practiced and how medicne will be practiced in that environment. If this effort is reasonably successful, it can suggest guidelines which will permit Michigan medicine to have some influence on its own destiny.

Future Trends
in Position Papers

An important side effect will be a broader knowledge of present and future trends by the many doctors who will read the position papers being obtained, thus building a membership more alert to and responsive to the society's planning.

Insurance and Other
Factors Probed

Of necessity a great portion of this work will concern itself in the insurance area. Such factors as government involvement, supply and demand, rising costs, broader benefits, controls, awareness and involvement of the profession, etc., are being probed.

Health Economics
Practice Economies

But while it is wrestling with the intricacies of the insurance mechanism, effects upon patient care, physician-patient relations, professional income, and doctor-to-doctor relationships, etc., both the broad extremes of health economics and the minutiae of practice economies need study.

Hospital Management
Multiple Coverage
by Insurance

Factors in hospital management and insurance often have marked effects upon patterns of practice. Automated record keeping, electronic patient monitoring, the establishment of therapeutic centers, home care, etc., will have an economic effect on the doctor. So will such things as the sale of multiple coverage of insurance, for people with multiple coverage use doctors and medical facilities more extensively.

Lower Cost
of Practice
Savings to Patient
Efficiency Expertise

Thus, as adequate health care for all Americans becomes a public policy, the investigation of those economics affecting medical practice must be extended. But, again, these broad subjects cannot be permitted to be so overwhelming as to remove the necessity of seeking ways in which the medical doctor can lower the cost of practice and pass these savings on to the patient. Experts in the field of time and motion studies, for example, are working closely with dentists and apparently have been successful in saving professional time and some costs. Such studies might be infinitely more complex in the case of the various medical specialties and practices but nonetheless may be valuable.

Questions

A. What will be the effect on the private practice of medicine when health becomes the largest industry in the country (only agriculture and construction are larger today)?	Health Third Largest Industry
B. What will the effect be of a doubling of the expenditures for health?	Larger Health Expenditures
C. What is the effect of health services on the economy at large ininsofar as prosperity is concerned?	Health Services and Prosperity
D. Can savings in the cost of medical care be gained if the comprehensive approach is used instead of the categorical approach?	Comprehensive Approach Less Costly Than Categorical
E. What would be the effect on the solo practice of medicine rendered on a fee-for-service basis if comprehensive programs providing a broad spectrum of services become more available?	Solo Practice and Comprehensive Care
F. What is the proper function of the outpatient department of a general hospital? What should it be in the future? What should be the relationship of the outpatient department of the hospital and the doctor's office? How should they compare?	Hospital Outpatient Department
G. A movement has begun to intergrate the community hospital (as a center of excellence) with extended care facilities to neighborhood centers and directly to the home through associated home care teams. What effect will this have on the private practice medicine? On the availability, cost, and quality of care received in the area covered?	Community Hospital Plus Neighborhood Centers Plus Home Care
H. Is there a noteworthy demand for a mechanism of prepaying for total medical and hospital care by a flat fee?	Flat Fee for Total Care
I. What place will closed panel direct service plans occupy in the future practice of medicine?	Closed Panel Direct Service Plans
J. What effect will future federal legislation have on group practice?	Legislation on Group Practice
K. What will be the effect on private practice and upon the confidential patient-doctor relationships if the physician personally supplies fewer and fewer of the services which are capable of being performed by personnel of lesser training?	Effect of Extended Health Team on Confidentiality
L. Would a time and motion study be valuable? 1. Of medical practice in the doctor's office? 2. Of medical practice by the doctor in the hospital?	Time and Motion Studies
M. Should a study be made of the probable influence of medical facilities—their nature, availability, and cost—upon the future practice of medicine?	Facilities and Medical Practice
N. What effect is the disappearance of medical indigence having upon 1. The income of the physician? 2. His patterns of charging for services? 3. His relationships with his patients?	Disappearance of Medical Indigence
O. What effect would changes (e. g., closed panel, group rates, comprehensive care) have upon 1. The quality of medicine the physician practices? 2. The professional standards he adheres to?	Effect of Changes

The New Look In Social Security Disability Program

BY C. ARTHUR HAKENEN,
DAVID P. GAGE, M.D.
BOTH OF LANSING

Mr. Hakenen is Chief of the Disability Determination Service, Division of Vocational Rehabilitation and Doctor Gage is Chief Medical Consultant for the Division.

There have been significant changes recently in the disability provisions of the Social Security Act. In 1965 the definition of disability was revised to include "impairment which has lasted or can be expected to last for a continuous period of not less than 12 months." Thus the definition now includes temporary as well as long-term impairments. The applicant's impairment must, however, be so severe that it prevents him from doing any substantial work appropriate for his education, training, and experience.

The 1967 amendments provide benefits for disabled widows and widowers at age 50 on their spouse's Social Security account, if they have no insurance coverage of their own. The widow or widower must have become totally disabled before or within seven years of the spouse's death.

The new amendments also made special provision for workers who became disabled before age 31: they now have a liberalized earnings test which takes into account their relatively limited opportunity to have earned Social Security Coverage. Other disabled persons must still have worked under Social Security for 5 out of 10 years preceding the onset of disability. The Social Security definition of blindness has also been liberalized.

THERE ARE NOW three kinds of disability benefits to those who qualify: (1) disabled workers under age 65; (2) unmarried disabled children over age 18 of retired or deceased workers, if the child's disability began before age 18 and continues to prevent any gainful work; (3) disabled widows and widowers, age 50 or over.

In Michigan these claims are adjudicated by our Disability Determination Service—Division of Vocational Rehabilitation, under contract with the Social Security Administration. We process between 2000-2600 claims a month. The eligibility requirements are more severe than in most disability insurance systems; the denial rate in Michigan and the other states is around 33%.

Adjudication Process

Application for benefits is made in the local Social Security office, which advises the person about eligibility and evidence requirements. The applicant must supply at his own expense sufficient medical evidence to establish the presence of an injury or disease. The Social Security Office gives him medical report forms to take or mail to the treating physician or facility. To the extent that they are available in his patient's chart, the physician is asked to report the history with therapy and response, physical and laboratory findings, and the diagnosis.

PHYSICIANS SUBMITTING reports do not have to determine whether or not their patient

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Social Security Disability Provisions at a Glance:

** Benefits are payable to disabled persons under age 65 and their dependents.
** Worker is considered "disabled" only if significant impairment keeps him from doing any substantial gainful work suited to his education, vocational skills, and work experience.
** Benefits are payable if disability has lasted or is expected to last 12 months or result in death.
** Benefits last as long as disability continues, or worker returns to job, or until retirement benefits start.
** Claimants may get free rehabilitation services through the Michigan Division of Vocational Rehabilitation.

is “disabled,” since this is the legal responsibility of the State Agency and Social Security.

When the medical and vocational evidence is in the file it is mailed to our Agency, where it is evaluated by a staff physician and a disability examiner trained in disability evaluation. The physician is responsible for assessing the severity, duration and remediability of impairment, as supported by the findings; the disability examiner considers the medical implications as they relate to the applicant's education, work experience, vocational skills and remaining work capacity. The team weighs all the evidence and arrives at a decision, which is signed by both members.

IF ADDITIONAL MEDICAL evidence is needed the Agency requests it from physicians, hospitals and clinics where the applicant received treatment. If not available from these sources our staff physician authorizes an independent medical examination, to document the file to the extent necessary for adjudication purposes; payment is made in accordance with the Michigan State Medical Society's own fee schedule for government agencies.

When our team completes its evaluation the file is sent to the central Social Security office for final review and action, to assure nationwide consistency in carrying out the law. Social Security also informs the applicant of the decision. Allowed claims are reviewed periodically to determine if disability continues, or if work capacity has been restored.

If the applicant is not satisfied with the decision, he has the right to appeal it. These levels include reconsideration of his claim, independent review by a Hearing Examiner, and judicial review in the Federal District Court.

Role of the Treating Physician

Medical evidence submitted by the attending physicians of this state continues to be more substantial and more objective, thus eliminating in many cases the need to send your patient for a consultative examination.

Not infrequently the State Agency might need an additional laboratory test or two in order to fully document the medical profile of the client and in such an instance we would prefer to, and do try to, obtain these from the attending physician.

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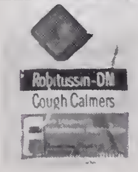

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SUGGESTIONS IN FEDERAL MANPOWER REPORT BRINGS REACTION FROM DOCTORS

Reactions were invited in the February issue of *Michigan Medicine* to the recommendations of the National Advisory Commission on Health Manpower. The Publication Committee again extends the invitation to MSMS members to voice their views of the many recommendations.

The February issue discussed some of the recommendations, and the subject was covered further by two speakers at the MSMS Conference on Health Planning in Detroit February 22-23. Comments of the speakers will appear in future issues.

Two MSMS committees are studying the new national report in detail, and the AMA Board of Trustees has several national committees looking hard at the recommendations.

Some medical leaders have expressed the opinion that these new national recommendations could well lead to more federal legislation in the medical-health field.

Following are some of the comments from MSMS members:

GEORGE T. KELLEHER, MD.
BATTLE CREEK

"The report of the National Advisory Commission on Health Manpower includes a recommendation that: professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

"Over ten years ago the Calhoun County Medical Society Committee on Third-Party Encroachment offered these Cassandran observations:

"Interest in third party encroachment is derived from the general feeling that interference is any proper transaction between two individuals by any third person or agency is improper not only because it is a trepass upon individual freedom of action, but, also because such transgression leads to direction of the transaction by the third party. In considering third parties as related to the medical profession and doctor-patient relationship, it is readily apparent that such intrusions, in transferring authority from doctor and patient, lead to control not only of the economic aspects of the relationship, but, inevitably to direction of the professional relationship, influence of the physician's judgements and treatments, direction of patients to physicians and physicians to patients and other forms of control of this formerly free relationship. The result, as has been seen elsewhere, is to convert the physician to a tradesman or technician and results in less efficient and pleasing patient care.

"Earlier the society had noted (April, 1957): —The appeasement of collectivistic groups in the past by the introduction of the service concept has actually been an invitation to them to continue the attack— The attack, obviously, has continued, and is continuing.

"At that time, it was pointed out that third party determination of whom is properly hospitalized means that the third party is, in fact, practicing medicine.

"In a mixed economy, such as has come to pass in this land, the constant push is by the collectivistic segments and each appeasement represents further victory in their drive toward complete political medicine.

"Organized medicine is obligated to engage in activities which improve the art and science of medicine. However, these activities proceed with the recognition that professionalism requires each professional to regard his peers (silly word—who anyplace, has a peer) as professionals, and accord to each the respect that reciprocates with the responsibility his fellow has accepted.

"Health insurance organizations and governments are not qualified to make patient care judgements and, consequently, should not participate in review procedures having to do with health care. Health insurance organizations should function as insurance organizations and insure against health care expense; some are interested in doing that—one insurance executive has disclaimed interest in health care by declaring, we are insurance men, not medicine men.

"The government has placed itself in the insurance business. If a patient wants to seek indemnification from this public carrier, let him so do; but, view this carrier as any other carrier—simply that and nothing more.

"As Dr. Wilbur has pointed out, if physicians were permitted to spend more time practicing medicine there would be less of a manpower problem. One way this might be accomplished is to eschew bureau-oriented activities unrelated to patient care which unnecessarily waste so much of the physician's time.

"The government might better serve us all if it directed some review procedures toward that peerless monoply, the U.S. Post Office; the cost of doing business with this non-competitive anachronism has doubled since 1958, and a study to develop its effective use might be labeled 'peerless review procedures.'

As Henry David Thoreau said in 1849:—"government never of itself furthered any enterprise, but by the alacrity with which it got out of it's way."

GORDON A. EADIE, M.D.
NEWBERRY

"The recommendation of the National Advisory Commission on Health Manpower which especially interests me is the one that states Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality. My comments are offered after a discussion with the staff of the local Helen Newberry Joy Hospital.

"It is well known, of course, that it is not easy to expand enrollment while improving quality in medical education and this has been one of the main road blocks toward increasing the number of medical graduates. I assume that the Commission's proposal to expand enrollment involves some sort of payment to the medical schools for each student enrolled or perhaps for each student beyond a certain minimum. On the surface this sounds like a desirable thing. It is well known that the major portion of federal support for medical schools has been in the form of research grants. These have little effect on student enrollment, therefore, some new approach would seem desirable.

"The other side of the coin, that of improving the quality of medical education could be stimulated through funds ear-marked for teaching staff salaries. Throughout the history of medical education the schools have had to depend largely for their instructors upon men in practice who draw most of their income from their practices. The wise use of Federal funds to pay full-time instructors would certainly help to answer this problem.

"While in agreement on the need for increased funds we must not overlook the equally important, if not more important, factor of the motivation of students. It is my strong conviction that the motivation of medical students to serve their

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patients and to raise the health level of the United States, especially of those people in the poverty groups, needs to be strengthened greatly. It would certainly be helpful if funds could be available to the medical schools to employ instructors who will inspire the students in these directions.

"Our hospital staff also wanted to emphasize the need for more general practitioners. You are undoubtedly familar with the project whereby students from MSU worked in the Western U.P. Health District last summer. Much more of this kind of thing is needed and this would be a valuable use of Federal funds."

RICHARD R. GALPIN, M.D.
BIRMINGHAM

"You have invited comments to the recommendations of the National Advisory Commission on Health Manpower.

"With respect to the recommendation for Federal funds and support of operating costs of medical schools, I would feel that this is a reasonable approach, and one which I feel is inevitable if we are to achieve an adequate number of physicians to serve the country.

One of the recommendations deals with minimum educational standards for foreign-trained physicians. I feel here that one would have to be very careful in the difinition of foreign. Certainly physicians trained in class A medical schools in Canada and the United Kingdom should be differentiated from students who are trained in other areas. But in general, I feel that the standards required are reasonable.

To carry out the recommendation that The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates; one would have to be careful here not to infringe upon the citizenship rights of graduates other than Americans. This is an area which would be approached cautiously.

"I have no quarrel with the recommendations that studies be undertaken on the development of guidelines for state licensure codes. My comments again would be favorable to the proposal that studies be made of the possibility of periodic relicensing of physicians and other health professionals. In general, I feel that as much as possible these areas must be left if possible to state authority and carried out at the state level. There is no question that the Federal government will become more increasingly involved in these areas, but I do believe that matters of licensure, licensing review, accreditation, must be left at a state level if they are to be efficiently enforced."

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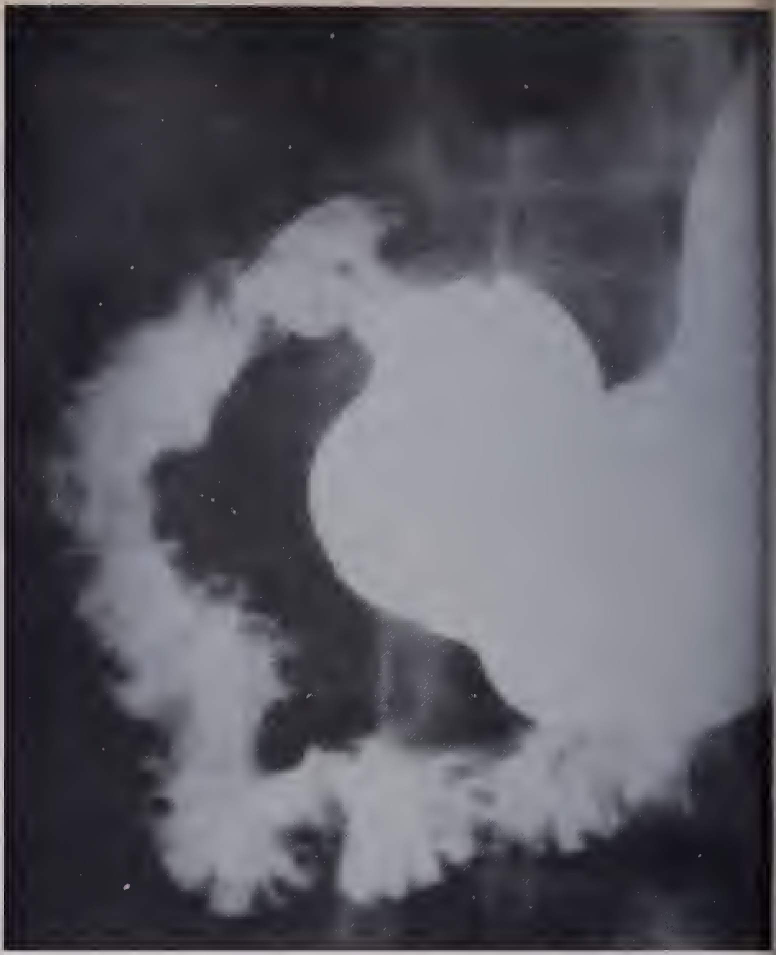

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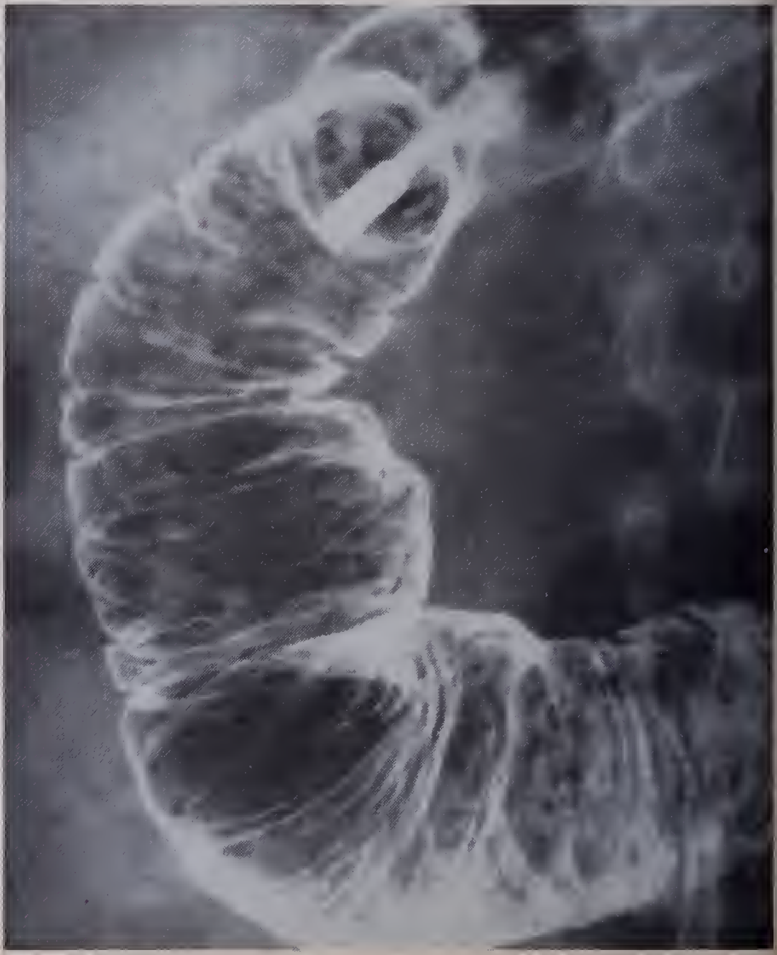

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In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthīne. The duodenum was intubated. Pro-Banthīne in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

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Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

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Poison Prevention Campaign Shows Limited Success

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

Deaths caused by accidents are on the rise in Michigan. The most recent figures published by the National Safety Council indicate that the National figure for 1966 was 5% above that of 1965 and the figure for the state of Michigan rose by the same percentage.

Over the past six years, there has been a steady rise in the number of deaths in our nation caused by accidents. This is in contrast to the decade from 1950 to 1960 in which there was a slow but steady decrease from year to year.

PERHAPS MOST discouraging to the physician, where he feels that he has the greatest control, is the fact that fatal accidents in the home increased by 3% from 1965 to 1966. More than 2,000 of these deaths could be attributed to poisoning by either solids or liquids of which the largest classification are medicines.

President Johnson has designated that the week of March 17-23 will be Poison Prevention Week. What have we as physicians accomplished through our efforts since the first Poison Prevention Week was designated by an act of Congress in 1960? If statistics do not lie, we have accomplished very little indeed. In the year, 1966, 2,100 people lost their lives as a result of poisoning and this represents a 10 to 15% increase over 1960.

Although it is always difficult to evaluate figures, it does appear that the short but intensive campaign using pamphlets in physicians' offices, radio and television messages, and store window posters is a rather futile means of attacking the problem.

WITHIN THE PAST 10 to 15 years a large number of poison information and therapy centers have been established throughout the United States and Canada. At last count twelve such centers existed in the state of Michigan. It is a little discouraging to note that there has been no general downward trend in the frequency of accidental poisoning nor in the death rate resulting therefrom. Admittedly, part of the apparent reason for this has been the improvement in gathering statistics and the greater accuracy of reporting, but it would seem that some sort of plateau should be reached.

The physician can and must play an important role in this safety campaign but it must be emphasized that the individual must be repeatedly informed and instructed in order to make an effective program in preventive medicine.

WAX
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LD

The fact that 50% of the fatalities are due to medications should make the physician even more alert to the problem. Of all medications involved in these fatalities, aspirin leads the list. Tranquilizers and barbiturates are next in order.

Among other household products causing a high percentage of fatalities are cleansing agents, particularly those with solvents added. Not far down the list are poisonous plants of which a variety of mushrooms are the most frequently indicated in the northern states.

MORE THAN HALF of the fatalities occur in children under four years of age. This is an age group that must be protected, they cannot be taught to avoid potentially dangerous situations. It is up to the family physician to repeatedly stimulate parents to remove the danger as much as possible and to enforce discipline when necessary.

Two further important points for the doctor to remember are to prescribe only the amount of medication which is needed for a particular episode and thus reduce the number of leftover medications that may be found around the home. Secondly, he should always be very specific about the instructions in the use of the medication relative to the size and frequency of the dosage.

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(as described in the package insert, for example)

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Researchers Complete State School Finance Study, Offer Recommendations

Michigan physicians for many different reasons are interested in the recently-published *Michigan School Finance Study Summary Report,* published by the Michigan Department of Education. Following are some excerpts for doctors to study for their many viewpoints as parents, taxpayers, community leaders, opinion molders, etc.

The *Summary* booklet lists the following nine conclusions as "the most important" drawn from the research during the 15-month study:

"(1) While enrollments in the elementary grades show signs of leveling off, and secondary enrollment continues to grow, both adult education and pre-kindergarten enrollments have been expanding.

"(2) There is great variation in the educational opportunities available to students in the state of Michigan.

"(3) There exist critical problems in the financing of urban education. These problems demand adequate financial support from the citizens of the state.

"(4) In comparison with many other states, vocational education in Michigan is inadequately supported from state funds. Special education services are not available in certain parts of Michigan.

"(5) The present procedures for the financing of school construction are very costly.

"(6) The pre-constitution portion of the teachers retirement fund is presently in serious financial difficulty.

"(7) Although there has been progress in the reorganization of districts, problems of inequality in educational opportunity and inefficient operation are still in existence.

"(8) The procedures for distributing state aid to school districts are overly complex, and do not accomplish the purpose of equalizing educational opportunity.

"(9) A revenue crisis also faces Michigan's nonpublic schools. There is a proportional shift in the student body from nonpublic to public school enrollment."

IN JULY, 1966, the Michigan legislature, acting upon a request from the Michigan State Board of Education, appropriated $200,000 for a comprehensive study of educational finance. The State Board subsequently appointed J. Alan Thomas, Director of the Midwest Administration Center, The University of Chicago, to direct the study. During the study, a large number of individuals — both professional and lay — assisted in the provision of information. Nonpublic as well as public school authorities took part in the collection of appropriate data.

The emphasis of the study was on an examination of educational opportunities available to the youth of Michigan, and of the relationship of these opportunities to the financing of education.

FOLLOWING ARE SOME of the findings of the study:

"The most favorable educational opportunities (in terms of a number of factors identified in the study) are available to students who live in districts of (a) high per pupil state equalized valuation, (b) high expenditures per pupil for education, (c) large size as measured by an enrollment of over 5,000 students, (d) high social class in terms of levels of income, quality of residence, and a preponderance of higher status occupations.

"The city of Detroit shows a much larger proportion of oversize classes than the rest of the state. The other major cities and the out-state districts differ only slightly along this dimension. The need for additional school buildings in the major cities is demonstrated by the fact that a much larger proportion of their schools are reported as exceeding capacity than are those in the out-state districts.

"THE QUALITY OF HOUSING and the income of residents of an attendance area are associated with the offering of classes for talented children, and the provision of the newer programs in mathematics, biological sciences, and physical sciences. Again, "high social class communities" are much more likely to have language laboratories in their junior and senior high schools, and to have provision for such facilities as closed circuit television and student study carrels. Urban schools with large proportions of Negro students enrolled show achievement levels which are lower than the levels in white schools in the same cities.

"The best qualified teachers (in terms of degree preparation and certification) are employed in the Detroit Standard Metropolitan Statistical Area, while the least well qualified are in the northern parts of the state. Unfortunately, the northern parts of the state also appear, on the basis of the data, to have an inadequate program of in-service training for teachers. Since the average age of teachers in northern Michigan is the highest in the state and because such teachers took their training at an earlier period, there is a greater need for an adequate in-service program.

"The shortage of teachers and other qualified supporting personnel appears to be greatest in the more densely populated metropolitan areas. This finding can be explained in part by the greater quantitative needs for personnel in these regions, both in terms of total student population growth and in terms of the desire to provide a broader program.

"THE LARGEST SINGLE factor in determining how much will be spent on the education of any given child in Michigan is the state equalized value per pupil in the school district in which he resides. State aid may reduce disparities in expenditure level, but it does not eliminate them.

"Of the 2,375,432 children enrolled in elementary and secondary schools in Michigan in 1966-67, 338,450 (14.2 per cent) were attending nonpublic schools. (The national nonpublic enrollment also comprises slightly more than 14 per cent of all pupils.)

"There are particularly strong concentrations of nonpublic school attendance in four Michigan metropolitan areas. In the Bay City Standard Metropolitan Statistical Area, 39.6 per cent of all elementary pupils are in nonpublic schools. In Grand Rapids, the figure is 28.2 per cent; in Saginaw and Detroit over 21 per cent.

Financing of Education in Michigan

"There should be additional emphasis on the use of state financial aid for reducing inequalities in educational opportunity for Michigan's students: (a) The most effective means to equalize educational opportunity in Michigan would be through transferring the responsibility for collecting the "allocated millage" portion of the property tax for education from localities to state government. This might, for example, result in a state-wide property tax rate of 12 mills for education, with a corresponding decrease in local property tax rates. These funds, together with addi-

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tional state revenue, would be used to finance a basic educational program for public students throughout the state; (b) If this program is unfeasible, a second alternative would be to transfer the property tax on industrial property from local to state responsibility. This property would then be freed from the local property tax and placed on state tax rolls. Michigan would then add to the basic state support a per student amount equivalent to the yield of this tax."

Vocational — Technical Education

"Michigan will need to devote considerable resources over the next decade to the extension of programs of vocational-technical education. Since the amounts of money involved are significant, every possible effort should be made to avoid waste and duplication. This involves careful state planning for the location of facilities and for program development. (a) Ideally, vocational centers should be part of comprehensive high schools. Where this is not possible, these facilities should be shared with post-secondary institutions. In some parts of the state, the intermediate school district may appropriately be authorized to build and equip vocational education facilities, and to operate them."

"As of December 31, 1966, there was a total of 918 local public school districts. This was reduced to 743 by September 1, 1967. Of these 918 districts, only 534 provided K-12 programs. Furthermore, 427 of the K-12 districts were inadequate by the established criteria, since they had fewer than 2,000 students enrolled in K-12 programs and/or less than $12,000 state equalized valuation per resident student. Thus, only 107 local school districts in the state were considered adequate, according to the three-fold criteria of total program, minimum enrollment, and financial support established by the State Reorganization Committee.

"Today, with eighty-three counties, Michigan has sixty intermediate districts that include all of the operating local school districts in the state. The boundaries of the intermediate districts are no longer completely contiguous with county lines, since they are determined by the attendance boundaries of the constituent local school districts."

THE STUDY SUMMARY REPORT contains a summary of the policy recommendations presented to the State Board of Education. "For the most part, the recommendations are stated as alternatives, on the basis of which appropriate policy may be developed," the *Report* states.

Financing of New Construction

"A reform of the procedure for financing construction will probably lead to increased state participation in the provision of revenues for this purpose. Three alternatives, based on experience in other states, are suggested:

"Alternative 1. The School Bond Loan Program might be revised, through the addition of a forgiveness feature for school districts which are not able on the basis of a reasonable millage to repay their existing indebtedness in a given period of time, say, 20 years. This amendment should result in a reduction of interest rates, as well as of total interest costs. It should also be an important step toward improving the fiscal solvency of school districts.

"Alternative 2. A second alternative is the development of an equalization program for the support of school building construction. This program would be similar to that utilized for the financing of current operation, with the state share varying inversely with local taxpaying ability. In terms of equitable treatment of school districts, the state would share in the debt retirement costs of districts which have already constructed their facilities.

"Alternative 3. A third possibility is in state sharing in the amortization of the cost of classroom space. For example, if the per pupil cost of space is $2,000 and the average expected life of a school facility is 50 years, the annual cost of space is $40."

School District Organization

"It is recommended that a Commission be appointed to develop a master plan for school district organization in Michigan. A concerted effort should be made to reduce the number of school districts in Michigan to a point where education can be most efficiently provided throughout the state.

"The present number of intermediate school districts should be drastically reduced. A minimum of 25,000 students is needed for an adequate intermediate school district, although there may be exceptions, depending upon the density of population in the area served by an intermediate school district. However, since travelling specialists, equipped, where necessary, with mobile units, can be employed, geographic area need not be a deterrent to the development of adequately staffed intermediate units in the northern part of the state."

PHYSICIANS INTERESTED IN obtaining a copy of the Michigan School Finance Study Summary Report should write to Dale Arnold, Information Officer, State Board of Education, 407 Bank of Lansing Building, Lansing.

100 Candles for Kalamazoo Academy of Medicine; Early Days Recalled

The Kalamazoo Academy of Medicine celebrated its 100th Anniversary recently.

On January 8, 1868, six physicians of the village of Kalamazoo founded the Kalamazoo Medical Association because the previous local medical organization, which covered several counties, had become too unwieldly.

Thanks to the late L. N. Upjohn, M.D., minutes from the meetings during the association's first three years of existence have survived.

After his mother died in the 1920's, Doctor Upjohn found the handwritten notes in the attic of her home. He passed the notes on to his son, E. Gifford Upjohn, M.D., who has spent a great deal of time deciphering the notes.

A list of the charter members of the organization is not included in the early minutes, but "those present" entries indicate that the organization grew rapidly.

Medical fees were one of the early concerns of the association; a committee was soon established to draw up a list of recommended fees.

Some examples:

Office consultation (common cases) $1-3; special consultations, 3-10; night visits, double fee and double mileage; additional charges for medicine furnished; obstetrical attendance and delivery, $10; if complications, $15-50; amputations above the knee, $30-100, below the knee, $25-50; dressing wounds, gunshot or other, $3-20; for writing letter of advice, $2-5; for medico-legal opinion, $5-50."

Water pollution was an early concern of the group. On October 18, 1870, members unanimously resolved that the water in the creek near the Holley Water Works could not be used for drinking or cooking without danger to public health.

Meetings involved presentation of papers, study reports, social time and afterward, "an hour was pleasantly spent at the hospital board of our worthy president in partaking of the good things set before us."

Eleven years after its founding, the association changed its name to the Kalamazoo Academy of Medicine.

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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BELOW in the article is a list of 128 Michigan communities seeking family physicians. AT RIGHT is a chart of 56 Michigan communities now registered for 134 specialists. Physicians seeking to locate in Michigan communities — and communites actively looking for physicians — are served through the MD Placement Service of the Michigan Health Council, 712 Abbott, East Lansing 48823.

Many Michigan Communities Registered With MD Placement Service of Health Council

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the MD Placement Program under the guidance of the Michigan State Medical Society. Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown. The Michigan Health Council currently has 128 communities that are seeking general practitioners.

UPPER PENINSULA: Calumet, Crystal Falls, Escanaba, Ewen, Hancock-Houghton, Iron Mountain, Ishpeming, Laurium, Marquette, Newberry, Rock, Saute Ste. Marie, Stephenson.

NORTH CENTRAL: Alpena, Atlanta, Boyne City, Cheboygan, Hillman, Gaylord, Lincoln, Mackinaw City, Mancelona, McBain, Onaway, Posen, Rogers City, Vanderbilt.

WEST CENTRAL: Alma, Baldwin, Barryton, Bear Lake, Big Rapids, Carson City, Cedar Springs, Cutlerville, Edmore, Evart, Fruitport, Grand Haven, Grant, Greenville, Hesperia, Holton, Howard City, Kent City, Lakeview, LeRoy, Manistee, Muskegon, Ovid, Portland, Ravenna, St. Johns, Scottville, Shelby, Whitehall, Zeeland.

EAST CENTRAL: Auburn, Bad Axe, Bay City, Byron, Caseville, Cass City, Coleman, Columbiaville-Otter Lake Area, Deckerville, Elkton-Bad Axe, Emmett, Flint, Gladwin, Hale, Lapeer, Lexington, Memphis, Metamora, Millington, Morrice, Mt. Pleasant, Port Huron, St. Clair, Sandusky.

SOUTHWEST: Albion, Allegan, Bangor, Baroda, Battle Creek, Benton Harbor, Buchanan, Burr Oak, Charlotte, Coldwater, Coloma, Decatur, East Lansing, Eau Claire, Fennville, Galesburg, Grand Ledge, Hastings, Hillsdale, Holt, Jackson, Jonesville, Kalamazoo, Lansing, Litchfield, Marshall, Mason, Paw Paw, Plainwell, Potterville, Quincy, St. Joseph, Sturgis, Tecumseh-Adrian, Waldron.

SOUTHEAST: Ann Arbor, Detroit, Grosse Pointe Woods, Milford, New Haven, Romeo, Royal Oak, Saline, Sumpter Township, Troy, Whitmore Lake, Ypsilanti.

Medical specialists also are in great demand in Michigan. Fifty-six Michigan communities now are registered with the Michgan Health Council's Placement Service, some needing only one additional specialist, others seeking several physicians in the same specialty and/or a wide number of medical specialties.

The Council is working with 33 communities that are seeking internal medicine specialists, 12 that are seeking psychiatrists and/or neurologists, 11 that are seeking surgeons and 16 that are seeking pediatricians. In addition to the 133 specialty openings listed, there is a need for a rheumatologist in Grand Rapids.

For more information concerning the openings, write or phone:

John A. Doherty, Executive Director
Michigan Health Council
P. O. Box 431
East Lansing, Michigan 48823
Phone: 337-1615

	Anesthesiology	Dermatology	Ear-Nose-Throat	Industrial Medicine	Internal Medicine	Ob-Gyn	Ophthalmology	Orthopedics-Orthopedic Surgery	Otolaryngology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Surgery	Urology	Rheumatology
UPPER PENINSULA																			
Calumet				X															
Crystal Falls					X														
Escanaba							X	X		X								X	
Hancock-Houghton			X		X			X				X						X	
Iron Mountain																	X		
Ishpeming-Negaunee					X			X				X							
Marquette		X	X											X					
Newberry														X					
Sault Ste. Marie			X		X	X	X					X							
NORTH CENTRAL																			
Alpena					X			X				X							
Charlevoix					X												X		
Gaylord					X														
Lake City													X						
Traverse City													X						
WEST CENTRAL																			
Alma	X					X											X		
Grand Haven					X			X	X					X				X	
Grand Rapids									X										X
Greenville					X	X											X		
Ionia														X					
Manistee					X		X	X				X						X	
St. Johns					X														
West Branch													X						
EAST CENTRAL																			
Flint													X						
Gladwin					X												X		
Lapeer					X							X							
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Albion					X		X												
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Coldwater					X		X						X						
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Galesburg					X														
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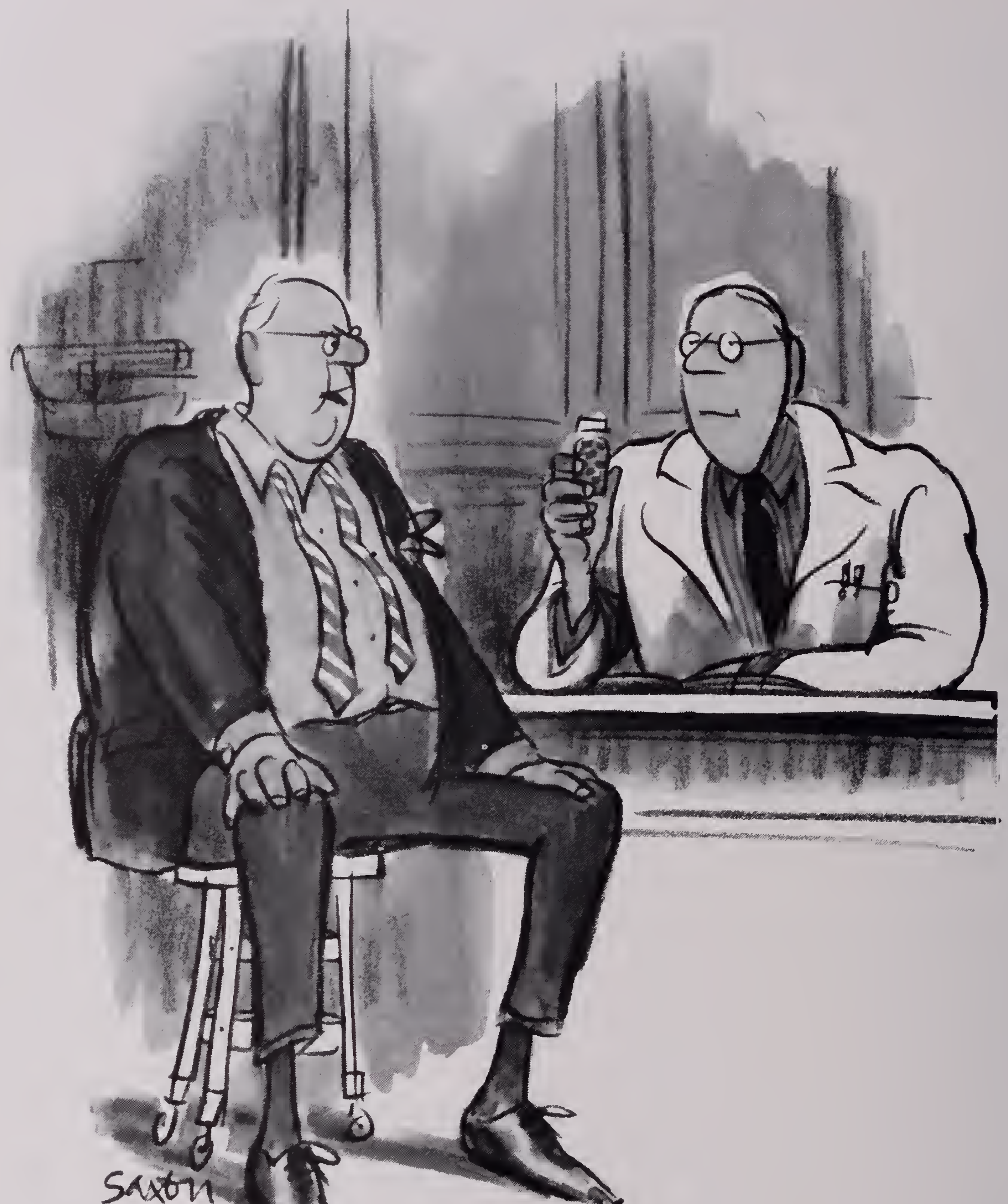
Lansing					X									X					
Marshall					X							X							
Mason						X													
Niles					X			X											
Paw Paw					X							X					X		
St. Joseph					X				X			X		X					
SOUTHEAST																			
Dearborn				X															
Detroit				X	X	X							X	X					
Howell					X														
Livonia						X													
Madison Heights			X				X		X			X							
Northville														X					
Pontiac													X	X					
Royal Oak					X														
Wayne					X														
MISCELLANEOUS																			
State-Wide Listings				X							X					X			
TOTALS	**1**	**1**	**6**	**4**	**33**	**9**	**8**	**7**	**5**	**2**	**1**	**16**	**9**	**12**	**0**	**1**	**11**	**6**	**1**



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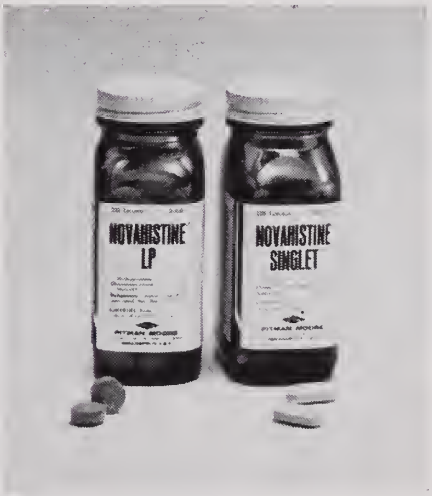

MHA Survey Confirms Rising Labor Costs

A survey of hospital statistics graphically illustrates the critical need by Michigan hospitals for new sources of capital to relieve the costs versus income squeeze, according to Allan Barth, executive director of the Michigan Hospital Association.

"Probably the most critical problem currently facing Michigan hospitals is where to find capital for much-needed improvements to facilities and equipment," Mr. Barth said.

He pointed out that because of the time required for reporting and tabulating the statistics, they include only the first indications of the impact of Medicare, Medicaid, the federal Wage-Hour Act and other governmental influences on rising hospital costs.

Mr. Barth said the statistics are compiled in an annual study of Michigan hospitals that also includes data collected from 33 Michigan osteopathic hospitals which are surveyed by the Michigan Osteopathic Hospital Association.

THE STUDY REVEALS that hospital operating expenses continued to increase more rapidly than total revenue, leaving the hospitals with a surplus of less than one-half of one percent to be used in meeting depreciation of facilities and equipment. This is the equivalent of only 25 cents per patient day.

While operating expenses rose to $363,624,000, voluntary non-profit hospitals took in $365,407,000 in total revenue, an increase of slightly less than $45 million over the previous year. This total revenue figure includes such items as grants, gifts, rentals, concessions and other non-patient payment sources.

Income from patient and third-party payments to Michigan voluntary hospitals in 1966 came to $350,572,000. Based solely on patient revenues against expenditures, the hospitals suffered a deficit of $13,052,000 or an average of $1.85 per patient day.

There was a 10.3 percent increase in hospital expenses per patient day in voluntary, short-term general hospitals. Costs increased from $47.64 in 1965 to $52.56 in 1966.

THE LARGEST PORTION of hospital expenditures was for payroll, which comprised 62.5 percent of overall hospital expenses in Michigan

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institutions. Nationally, the average total expense per patient day was $48.32 with payroll making up 61 percent of the total.

In the overall survey of statistics from 293 hospitals compiled by the Michigan Hospital Association, 151 were in the category of voluntary, short-term general care. These institutions and the hospitals included in the psychiatric group have 73 percent of the state's hospital beds and admitted 66 percent of the patients in 1966.

Other information obtained from the hospitals in their responses to the survey included:

— Admissions throughout the state showed a rising trend in 1966, with a total of 1,333,025 and a daily census of 67,944 patients as compared to 1,299,148 and 67,823 in 1965.

— Births in Michigan showed a slight increase in 1966. The total number of births in 1966 was 165,794, a rise of 311 over 1965.

— The ratio of full-time hospital employees to patients in Michigan voluntary, short-term hospitals was 268 required for every 100 patients. This represents an increase of 11 employees per 100 patients over 1965. A major factor in this increase can be attributed to staff increases necessitated by handling of Medicare claims.

— Payroll continued as the largest single budget item for voluntary hospitals, constituting 62.5 percent of the overall budget. For all hospitals, payroll expenditures amounted to 66 percent.

— Voluntary, short-term general hospitals accommodated more than 65 percent of all the persons admitted to Michigan hospitals in 1966. Osteopathic hospitals accepted just under 12 percent of all patients admitted.

— The average stay of Michigan voluntary hospital patients was 8.1 days, compared to the national average for these hospitals of 7.9 days.

— On the average, for every dollar spent in providing patient care in Michigan's non-profit general hospitals, 4.0 percent was for housekeeping; 10.1 percent for dietary; 3.6 percent for pharmacy; 1.4 percent for medical records; 1.6 percent anesthesiology; 6.9 percent for laboratory; 5.8 percent for radiology; 13.8 percent for administration and general supervision; 0.6 percent for inhalation therapy; 5.0 percent for medical surgical and intern-resident services; 5.0 percent for plant operations; 2.4 percent for laundry and linen services; 30.3 percent for nursing service, education, operating room and delivery; and 0.5 percent for other expenses such as social services, blood bank, ambulance, out-patient services and depreciation.

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Editorials Praise Efforts Of MSMS in Various Fields

Every week, Michigan newspapers voice their editorial opinions about various medical and health subjects.

Often these editorials deal with the need for physicians and often they describe efforts of the medical profession to recruit toward this same common goal.

Following are excerpts from several editorials which appeared recently:

The *St. Joseph Herald-Press* is one of the many Michigan newspapers to join the efforts to recruit more doctors. A recent editorial told its readers that, "Gifted young people of ability will find a life of work in the medical arts highly rewarding, spiritually and materially. Those who enter this field should dedicate themselves to maintaining the high standards that the profession has established."

The fine performance by Michigan doctors in international programs was lauded in the Michigan Mirror column which many newspapers print each week. The following are excerpts from the column as it appeared in the *Novi News*:

"Michigan doctors have an outstanding record contributing their services around the world. Only California, where more doctors are licensed, can match it.

"The Hope hospital ship, which visits countries inviting it, has 31 physicians and two medical students from Michigan on its staff. For this volunteer service, medical personnel receive no pay, and only moderate living expenses.

"Ill and injured Vietnamese are cared for by a separate program sponsored by American Medical Association and supported by the Michigan State Medical Society. Eight Michigan doctors are currently working in Vietnam to help fill the gap left by their need for military service. Vietnam has only 1,000 in the whole country and 650 of these are in the Vietnam army. The remaining 350 care for the country's 15 million civilian population.

"American physicians receive $10 per day living

Say you saw it in Michigan Medicine

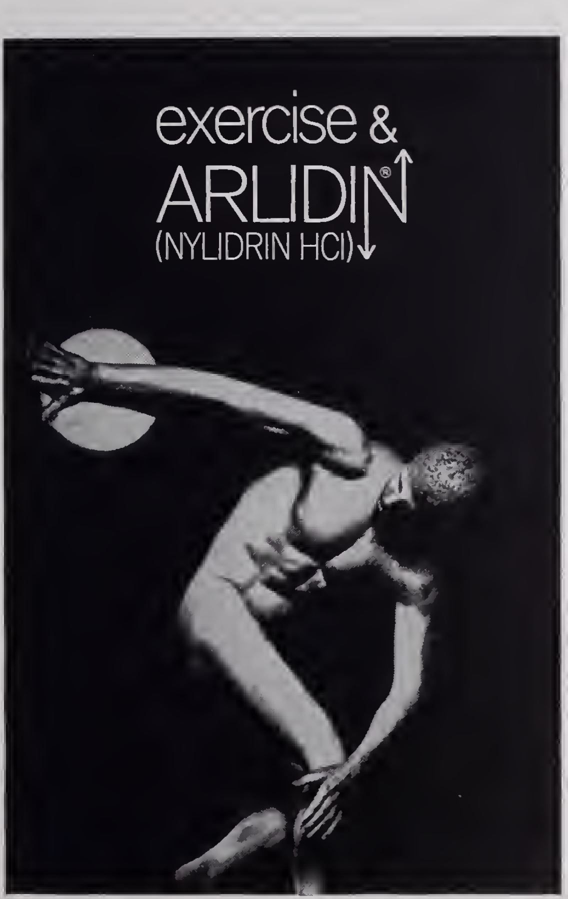
expense, and travel expenses to and from Vietnam. They serve for two-month periods in one of the 16 provincial hospitals.

"MEDICO is another plan which involves Michigan physicians overseas. It is administered through CARE. Six doctors from the state participated in MEDICO in Asia and Africa.

"Charles H. Moseley, M.D., director of the AMA plan, explains, 'This program has done more to improve the image of the American physician than any I know of. The Vietnamese people know that a physician who closes his office and comes as a volunteer to their land is making a sacrifice for them.' "

"Times are indeed changing. Integration in the health professions as between medical doctors and osteopaths is beginning"; so stated an editorial in the *Adrian Daily Telegram*.

The editorial described the action of the MSMS House of Delegates to permit osteopaths to apply for associate membership in county medical societies. The Adrian paper observed that "the long-standing feud in the medical profession between the medical and osteopathic physicians is easing." The editorial noted that MSMS "has opened its doors to the osteopaths."



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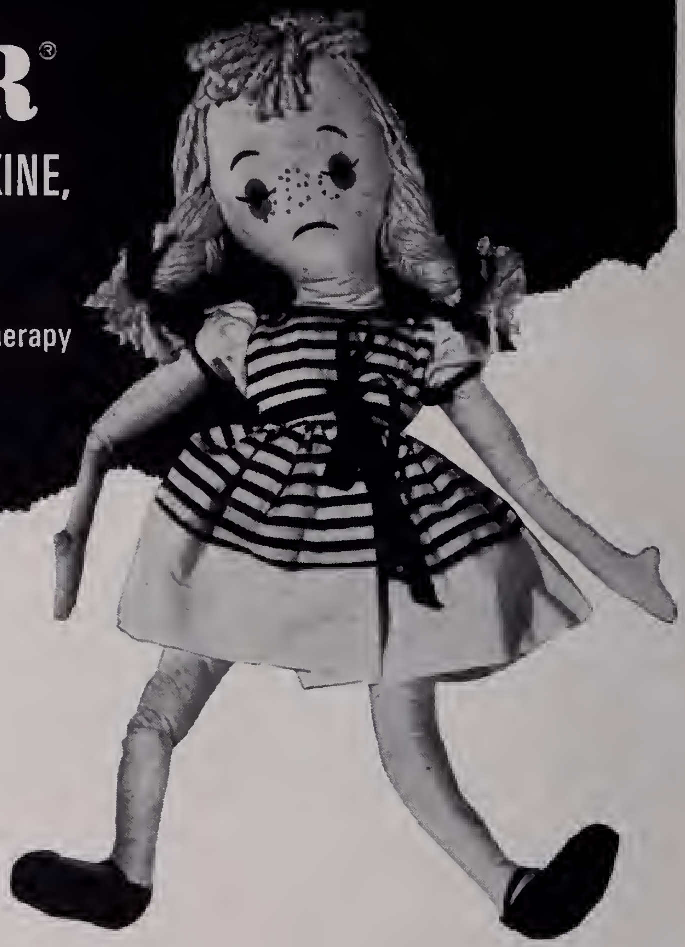

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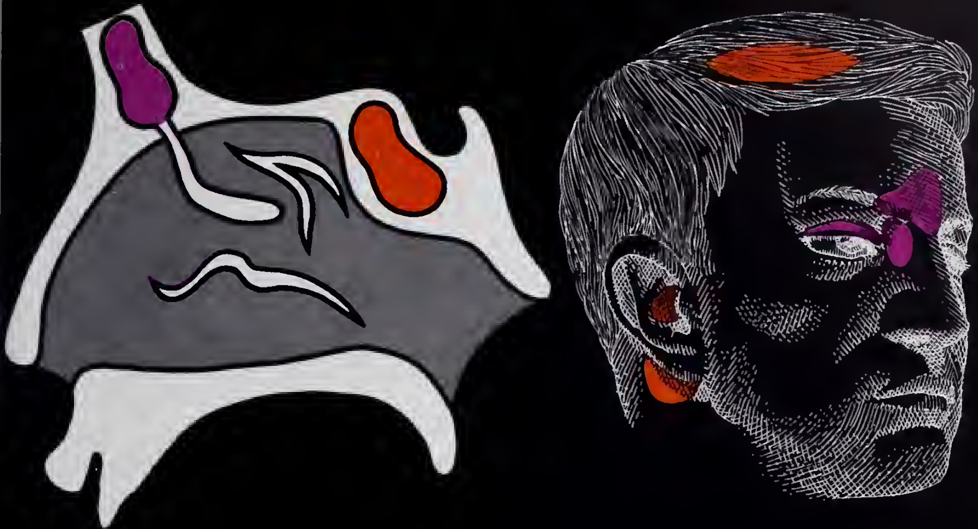
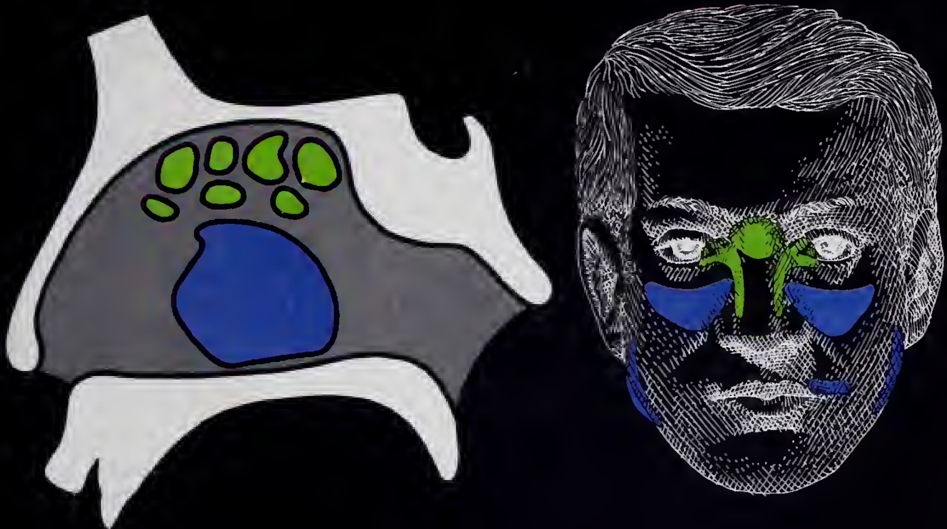
Sources of sinus headache



REGION OF SENSATION

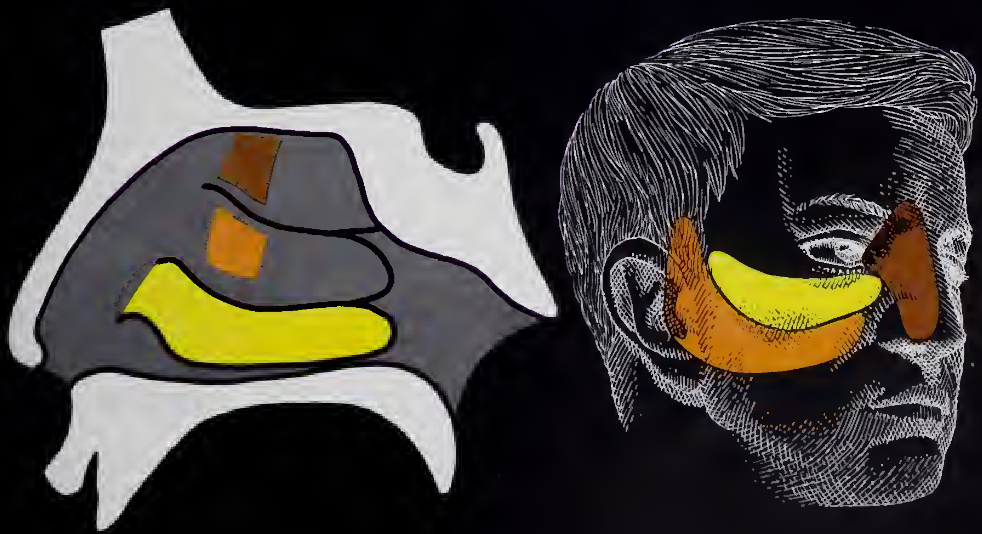
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



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New Asset Management Plan for MSMS Approved by Delegates in Special Meeting

The MSMS House of Delegates, in special session February 14, adopted the recommendations of the MSMS treasurer to reorganize the MSMS financial structure; and then took action also to amend the bylaws and to authorize the MSMS Council to mortgage the headquarters building.

The special session was called by Speaker James B. Blodgett, M.D., upon the request of the MSMS Council to consider the recommendations of the Treasurer John R. Ylvisaker, M.D., to revise the management of MSMS assets.

IN HIS OPENING comments, Doctor Blodgett explained that, in September, the 1967 House of Delegates Reference Committee on Ways and Means had recommended approval "in principle" of the suggestions offered by Treasurer Ylvisaker. The MSMS Council, Doctor Blodgett reported, studied the recommendations further at two fall meetings and obtained statements from attorneys and tax consultants. Then the Council Finance Committee approved the recommendations as did the Council. The Council then asked that the special meeting of the House "be called prior to March 1, 1968 to consider the Treasurer's report," to specifically authorize implementation of the plan.

Doctor Ylvisaker, in his presentation, stressed that the new asset management program "cannot and will not avert dues increase or assessment if increase in future operation places such demands on MSMS."

In advocating a mortgage Doctor Ylvisaker pointed out that "it spreads this debt over the useful life of the building and apportions its costs progressively to succeeding current members."

DURING THE DISCUSSION, there was some opposition voiced to the proposals by delegates who expressed a different philosophy on finances.

In making the motion to adopt the Treasurer's proposals, Paul T. Lahti, M.D., Oakland delegate, declared, "For MSMS to be effective, we must have a sound, progressive financial program."

Doctor Lahti then moved that the Treasurer's report be adopted and approved; and further that the Council implement these recommendations immediately and expeditiously."

THE MOTION WAS carried after a roll call vote.

After the House adopted the revised MSMS asset management plan Speaker Blodgett adjourned the first meeting and invited delegates to confer with a special bylaws reference committee. The House was called back into session for its second meeting, and the reference committee report to adopt necessary changes in the bylaws was approved. The House then approved a motion to make the necessary changes to provide for the implementation.

FINAL ACTION OF the afternoon was a specific motion to authorize the MSMS Council to mortgage the building and proceed with the necessary legal instruments.

The meeting was held at the Wayne County Medical Society headquarters.

After the Council completes the mortgage on the building, the Council is authorized as part of the House action to establish three fund categories. One will be the Operational Fund, another will be a Capital Reserve Fund for contingencies and replacement of depreciable fixed assets, and the third will be a Managed Investment Fund to provide for extended service to the public, MSMS, component societies and the members.

THE FIVE GENERAL objectives of the Treasurer's plan, as outlined by Doctor Ylvisaker, are as follows:

"1) The retirement of current expenses out of current income (a positive rather than a negative cash flow position).

"2) The proper management of debt both by securing such debt for the lender and amortizing the amount within the Society budget and with progressive scheduled long-term retirement based on membership participation in the benefits which the debt has purchased for the Society.

"3) The provision of funded reserves adequate to protect the Society against demands caused by recurring predictable capital needs as well as unpredictable contingency needs.

"4) The establishment and intitial funding of a service reserve or trust, the income and growth of which may provide resources for a positive service program consonant with the purposes and responsibilities of the Society.

"5) The proper management of money derived from dues: a) To provide fixed dollar amounts sufficient to meet fixed dollar needs; b) To protect the purchasing power of dollars designated as long-term reserves; c) To achieve maximum income stability and growth where possible to protect the members against unwarranted additional cash demands either as dues or assessments."

WCMS Honors WSU; Check Aids Stapleton Reading Room

The Wayne County Medical Society, at a special program on February 5, sponsored an evening celebration in honor of Wayne State University School of Medicine on it Centennial Anniversary.

A highlight of the evening was the presentation of a check for $31,000 from the Wayne County Health Foundation and individual members of the Wayne County Medical Society for the Doctor William J. Stapleton Reading Room which will be part of the new medical library at the WSU new medical center.

Donald N. Sweeny, Jr. M.D., president of the Wayne County Health Foundation, presented the check to Edward M. Varden, M. D., president of the Board of Trustees of the Medical Library Fund.

Later in the evening, four talks were given on "A Historical View of the School of Medicine, Wayne State University." Alfred H. Whittaker, M.D., of the Wayne State University Board of Governors, outlined "The First Fifty Years"; Vice-President Gordon H. Scott, Ph.D., spoke on "The Last Fifty Years"; Dean Ernest D. Gardner, M.D., discussed "The Present Picture" and President William R. Keast, Ph.D., took a glance into the future with a talk on "The Next Fifty Years."

Chairman for the evening was Don W. McLean, M.D., with Frank B. Bicknell, M.D., president of Wayne County Medical Society, presiding.

BEGIN PG SERIES, MAR. 14, OAKLAND U.

A series of seven lectures on "Recent Advances in Clinical Physiology" will begin Thursday, March 14, 7:15 PM, in the Science Building at Oakland University for all interested physicians.

Topic of the first lecture is "Salt and the Kidney," by Arthur Vander, M.D., associate professor of physiology at the University of Michigan.

Complete details are available from Kenneth Meade, Director, Postgraduate Professional Education Programs, Oakland University, Rochester.

The MSMS Legal Affairs Committee meets many times at MSMS during each session of the Michigan Legislature to review the scores of health bills in terms of Society policies set forth by the house of Delegates and Council. Some of the Committee are pictured in a typical working meeting.

Medicine-Religion Workshop, March 27

"A physician knows what faith can do in the total health care of a patient. Often, in dark moments, it becomes as powerful as the most potent vaccines, as impressive as the instruments of modern medicine in restoring the blessings of health," said Winslow G. Fox, M.D., Chairman of the MSMS Committee on Medicine and Religion, in discussing the importance of a medicine and religion workshop in East Lansing, March 27.

Chairmen of county medical society medicine and religion committees have been invited to participate at the MSMS Headquarters.

Doctor Fox, of Ann Arbor, will give the welcoming address in the morning session. Paul B. McCleave, L.L.D., Director, and Robert L. Coons, both from the AMA Department of Medicine and Religion, will also speak to the participants in the morning.

Luncheon speaker will be Leroy Augenstein, Ph.D., chairman of the bio-physics department at Michigan State University.

In the afternoon, a series of dialogues or moral and ethical issues facing doctors today will be held. Among the topics are: Do DNA synthesis and heart transplants change our view of life? Does man have a moral right to die? What about the exchange of information between a doctor and clergy? Family Life Education; drug addiction and hallucinogens.

Committee Rosters Available From MSMS

Physicians interested in obtaining copies of the MSMS Committee Rosters can write to the MSMS Headquarters, P.O. Box 152, East Lansing 48823.

Careers Mobile Rolls March 15

The Health Careers Mobile, containing new exhibits which outline the health curricula at Wayne State University, Michigan State University, and the University of Michigan, will move to Mercy College in Detroit, Friday, March 15.

Sponsored by the Detroit Commission on Youth, the Health Careers Mobile will serve as part of a "Youth Conference on Health Careers" for all public and parochial schools in Detroit. The unit will remain at Mercy College for weekend viewing by students and the public.

After the Mercy College visit, it will begin a tour of Southeastern Michigan, including Dearborn, St. Clair Shores, and Birmingham.

In April and May, the Health Careers Mobile will participate in Healthoramas at Northland, Eastland, and Westland, in Detroit, sponsored by the Women of the United Foundation.

MSMS Group Going To AMPAC Rally

The AMPAC Board of Directors will hold its annual workshop in Washington, D.C., on March 9-10. The workshop will be aimed at the development of successful and effective candidate support committees at the congressional district level.

Attending from Michigan will be Vernon Bass, M.D., Frank B. Bicknell, M.D., E. J. Geist, M.D., Robert J. Frank, M.D., James J. Lightbody, M.D., and Ralph T. Wills, MSMS staff.

One of the featured speakers will be Frederick Van Duyne, M.D., of Flint, Republican chairman of Genesee County. He will discuss "Opportunities Unlimited."

120 Attend District SAMA Event at MSU

Students from 10 medical schools discussed new approaches to medical education and problems of health care at an SAMA regional meeting February 2-4 at Michigan State University.

Hosting the conference was the MSU chapter of SAMA, with financial support from the Ingham County Medical Society and other organizations.

MED ASSISTANTS TO MEET APRIL 21

The Michigan State Medical Assistants Society will hold its 11th Educational Seminar at the Pick-Durant Hotel, Flint, April 21.

Ethel Lundgren, seminar chairman, announces that the theme of the day will be "Medicine and Law."

Ground Broken by WSU For Basic Science Building

The groundbreaking ceremony for the Basic Science Building of Wayne State University School of Medicine was held February 14 at the Medical School campus.

When completed, the $24 million structure will be the largest state building ever constructed in terms of both cost and size.

A teaching and research facility, the Basic Science Building will be located at the southeast corner of Canfield and Brush in the new Medical Center complex.

The structure will help to permit WSU to increase its entering class from 125 students to 200.

The Basic Science Building will house the departments of anatomy, physiology, pharmacology, biochemistry, microbiology, and pathology, as well as administrative and service facilities.

Student study areas will include sections equipped with calculators, typewriters, and fixed microscopes. A television studio with facilities for color or black-and-white production will be located on the first floor. Closed circuit television will link student classrooms with work going on in area hospitals.

Total cost of the new Medical Campus, covering some 25 acres, of which the Basic Science Building will be a significant part, is estimated at $56 million.

Henderson to Chair U-M Ophthalmology Unit

John W. Henderson, M.D., an ophthalmologist on the University of Michigan faculty since 1945, was named chairman of its department of ophthalmology Friday, (Jan. 19). On July 1, he will succeed Doctor Bruce Fralick, who is retiring after 40 years of service. Doctor Henderson was the unanimous first choice of a faculty committee which searched throughout the United States and Canada for a new chairman.

Doctor Henderson, a native of Clarinda, Iowa, is a graduate of Occidental College and the Northwestern University Medical School. He was trained as an ophthalmologist at U-M by Doctor Fralick. He also studied neuroanatomy at U-M and was awarded a doctor of philosophy degree in that field in 1948.

Sweeny Named to Chair New AMA Committee

Donald N. Sweeny, Jr., M.D., Detroit, has been named chairman of an AMA ad hoc committee to work with a joint conference committee set up by the National Association of Blue Shield Plans and the American Medical Association.

Highlights of January 24 Council Meeting

The Council authorized two officers to attend as official representatives the 1968 Upper Peninsula Medical Society meeting in June.

Dates for the 1968 mid-summer session of The Council were approved, July 28-31.

MSMS approved a request for it to co-sponsor with the Michigan Hospital Association a meeting for physicians, administrators, and trustees, to discuss physician-hospital relations.

The Council named Robert E. Rice, M.D., Greenville, as Delegate, and Brooker L. Masters, M.D., Fremont, as Alternate Delegate to the Michigan Health Council.

MSMS authorized the following representatives to attend meetings: 1968 Association Public Affairs Conference, State of Michigan's Director's Annual Conference with Local Public Health Directors. AMA 64th Annual Congress on Medical Education, AMA Regional Workshop for State Chairmen of Committees on Medicine and Religion, Institute of Medicine of Chicago "The Doctor and His Hospital" Workshop, American Association of Medical Society Executives Orientation School for new Medical Executives and the AMA 21st National Conference on Rural Health.

The Council received a detailed report of the AMA Conference on Health Care for the Poor, submitted by Paul T. Lahti, M.D., who attended the Conference as MSMS representative.

The Council provided direction to the Legal Affairs Committee re Chiropractic Legislation.

The report of Michigan Medical Service presented by John M. Wellman, M.D., Chairman of the Board, discussed (1) operations, (2) building plans, (3) staff appointments, (4) alternate negotiations and new Blue Shield programs, (5) utilization review, (6) government program changes and (7) physicians participation.

The Council's Publication Committee heard a report on Journal Advertising and other details regarding the publication of *Michigan Medicine.*

Speaker James B. Blodgett, M.D., reviewed plans with The Council for the Special Session of the House of Delegates.

Minutes of the following committees were received with thanks and recommendations contained therein approved with amendments: Awards, Mental Health, Liaison with State Board of Registration in Medicine, Legal Affairs, Cancer, Aging, Eye Care, Alcohol and Drug Dependence and Committee on Rehabilitation.

The following elections and appointments were made by The Council: Kenneth H. Johnson, M.D., Secretary; John R. Ylvisaker, M.D., Treasurer; George H. Lowrey, M.D., Scientific Editor; Brooker L. Masters, M.D., Assistant Secretary; C. Allen Payne, M.D., Assistant Treasurer; Hugh W. Brenneman, Executive Director; and Warren F. Tryloff, Assistant Executive Director.

STACK RECEIVES JAYCEES AWARD

Jack Stack, M.D., of Alma, was recently selected as one of the "Five Outstanding Young Men of Michigan" by the Michigan Jaycees at their winter meeting in Saginaw.

"Many of our cynical friends question the validity of contributing a large segment of one's energies to community service to partisan politics, and to professional organizational responsibility," commented Doctor Stack upon receiving the award.

"My reply to them is that if I and not willing to participate in the search for the solutions to the problems of the times then I have relinquished this privilege to others who are willing to become involved," he continued.

"If I am not pleased with their solutions to the problems I shall have no recourse nor any right to criticize," Doctor Stack said.

"If my children grow up and find this society an undesirable world in which to live they will ask me what I do to protect it and to improve it for them and I must be able to answer, 'I did the very best I could,' " the Alma physician continued.

"I believe that we must be involved in the action and passion of our times or we shall run the risk of being judged not to have lived," he concluded.

Barnard Gives Galens Lecture

The South African surgeon who performed the world's first human heart transplant, Christian Barnard, M.D., gave the annual Galens Lecture at the University of Michigan.

Doctor Barnard spent March 6 at the medical school in a round of discussions and visits with students and faculty members.

From Ann Arbor, Doctor Barnard went to the University of Minnesota where he had taken medical training.

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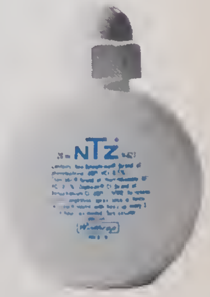

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When oppressive feelings and psychic tensions are severe and cooperation with the physician poor, it may be helpful to add adjunctive Valium (diazepam), 10 mg or 5 mg t.i.d., to the coronary patient's regimen. Valium (diazepam) helps to promote the needed relaxation that the patient requires to make him less preoccupied with his condition and more inclined to cooperate in, and benefit from, the total therapeutic program. Valium (diazepam) may be administered in the presence of secondary depressive symptoms.

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(5 mg or 10 mg t.i.d.)

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(2 mg or 5 mg t.i.d.)

The heart patient who leaves the hospital to enter a period of slow restorative treatment is often forced to make emotionally difficult adjustments. The resulting stress of this period may again cause psychic tension to mount to potentially harmful levels. To augment your reassurance and the emotional support of his family, a 2 mg or 5 mg t.i.d. regimen of Valium (diazepam) can reduce psychic tension and thereby help the patient to accept necessary restrictions more calmly, and to adjust to his illness more realistically.

Getting back to work presents additional stresses for the cardiac patient. There are often anxiety-producing features in the job which can be more significant than the physical or intellectual demands of the work. Valium (diazepam), 2 mg or 5 mg t.i.d., may be a useful adjunct to reduce overreaction to these stresses and thus help the patient to face job situations more calmly and rationally.

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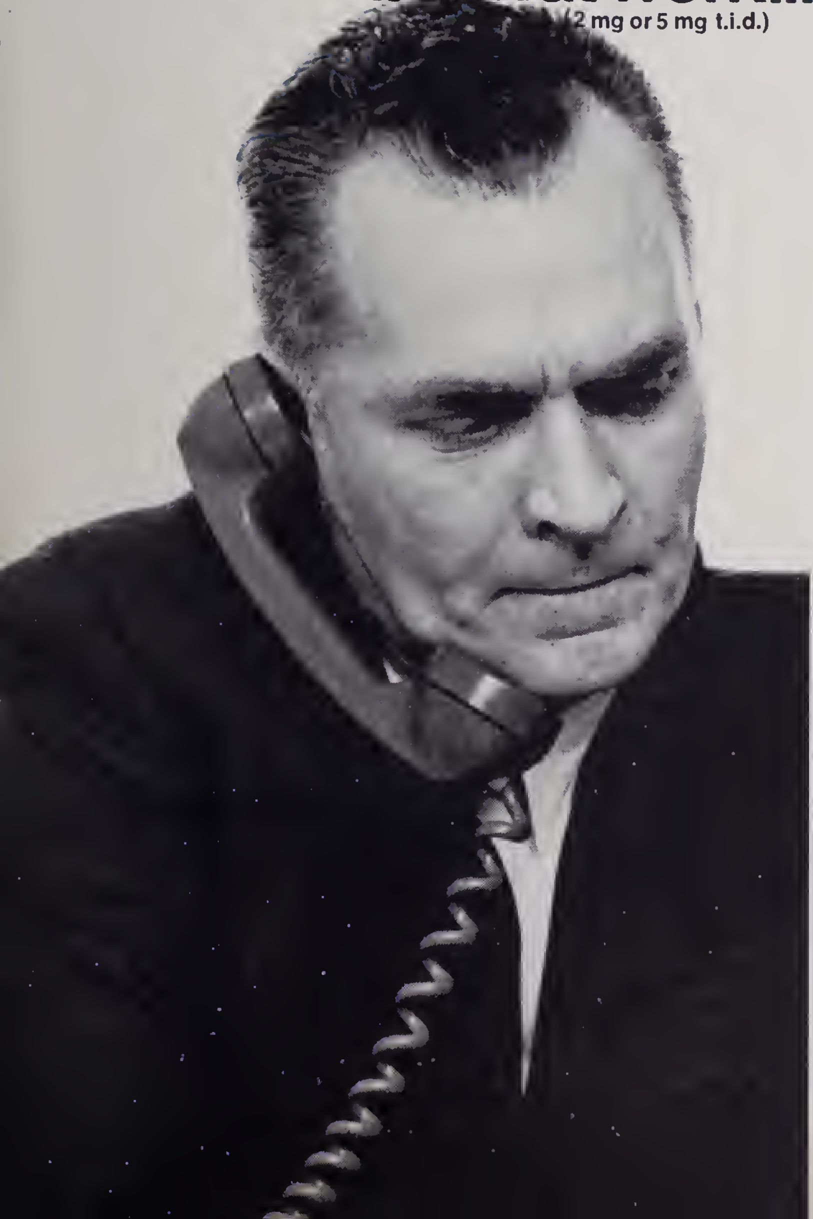

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and for the patient with tension-induced sleeplessness, remember the value of an extra tablet at bedtime

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, moderate to severe psychoneurotic states with anxiety, apprehension or agitation alone or with depressive symptoms; somatic complaints which are concomitants of emotional factors; acute agitation due to alcohol withdrawal; muscle spasm associated with cerebral palsy and athetosis.

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects — particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

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References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I.E., Personal communication.

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WSU Med Alumni Conclave May 15, Special This Year

The Golden Anniversary celebration of the Wayne State University School of Medicine's class of 1918 will be held May 15 at the Sheraton-Cadillac Hotel in Detroit.

Sponsored by the WSU Medical Alumni Association, the day will include a clinical section and a banquet in the evening celebrating the 100th anniversary of the founding of the medical school and honoring the class of 1918.

The clinical meeting will be held from 8:30 a.m. to 4:30 p.m. The banquet is at 7:00 p.m.

GENERAL THEME OF the day will be "Human Sexuality and Modern Marriage." Two of the speakers will come from the Bowman Gray School of Medicine in Winston Salem, North Carolina. Clark Vincent, Ph.D., Director of the Behavioral Sciences Center and professor of sociology, will speak on "Human Sexuality: A General View." Robert Coombs, Ph.D., assistant professor of sociology, will discuss "Acquired Sex Attitudes and Information — Role of Home and Parents."

"Changing Sexual Expectations in Women — The Special Role of the Physician's Wife," will be the topic of Peter Martin, M.D., clinical professor of psychiatry at Wayne State University's Medical School.

Speaking on "Marriage and Sexual Problems in Modern Society: An Overview of Pre-Marital and Marital Counselling" will be Richard H. Klemer, Ph.D., professor of family relations at the University of North Carolina in Greensboro.

"Psychodynamics of Teaching Medical Students Sex Education" will be discussed by Harold Lief, MD, professor of psychiatry and director of the division of family study, University of Pennsylvania, Philadelphia.

"I think the topic is very important in the light of the so-called sexual revolution," said Mario Petrini, MD, President of WSU Medical Alumni Association.

"THE PROGRAM SHOULD be helpful to the private practice physician," continued Doctor Petrini, "because more and more people are bringing their sexual problems to him and the physician is often poorly prepared to counsel people in this area."

"I would like to emphasize," Doctor Petrini added, "that the program this year is designed for doctors and their wives. Also we plan to invite other professionals who are involved in this field."

After five talks are given throughout the day, speakers will get together for a late-afternoon panel question and answer period.

DURING THE BANQUET in the evening, a special citation will be given to Duncan J. McColl, MD, of Port Huron. Doctor McColl will be 100 years old this year. He is the oldest living alumnus (1893) of Wayne State University and was born the year in which the Medical School was founded. Doctor McColl was named Michigan's Foremost Family Physician in 1954 by MSMS.

Coming in June

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at the world's largest medical meeting, the Annual Convention of the American Medical Association.

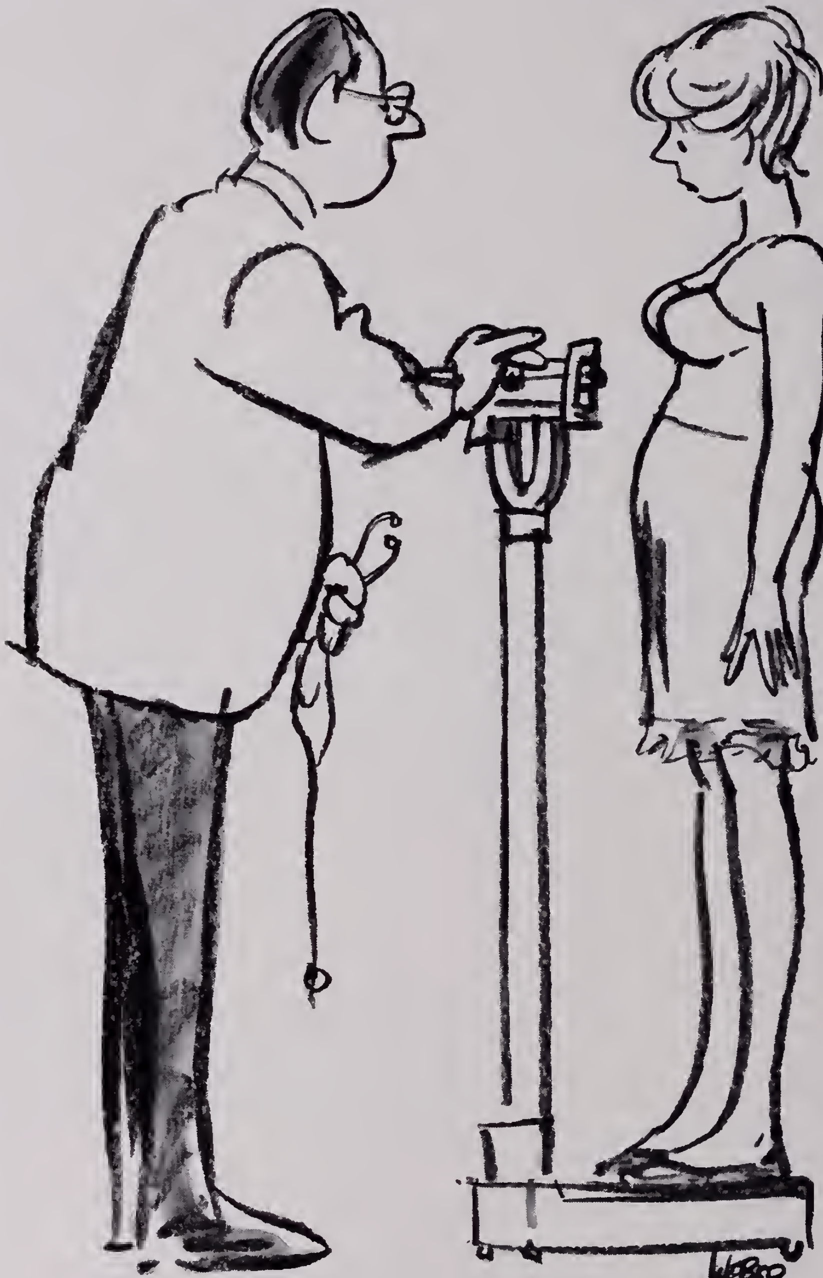
The 117th Annual Convention of the AMA will be held June 16-20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advanced malignant disease.

Four General Scientific Sessions will be presented and the 23 Scentific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.



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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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HORNE TO ADDRESS MATERNAL WELFARE CONCLAVE, MARCH 26-27

One of the major addresses, which will have a high public and physician interest, at the Seventh Annual Conference on Maternal and Perinatal Welfare in Flint, March 26-27, will be a discussion of "Infertility," by Herbert W. Horne, Jr., M.D., from the department of Obstetrics and Gynecology, Harvard Medical School, Brookline, Massachusetts.

Doctor Horne is presently doing research on population problems, population control, and infertility. Before beginning his practice in infertility, he was a research Fellow with John Rock, M.D.

Chairman for the morning session of the conference on March 26 is William W. Jack, M.D., Grand Rapids, immediate past chairman of the Committee on Maternal Health of MSMS. Banquet chairman is James E. Harryman, M.D., Muskegon, present chairman of the committee.

The cocktail hour this year at 6:00 p.m., March 26 is being sponsored by Ortho Pharmaceutical Corporation of Raritan, New Jersey. Ortho will sponsor an exhibit at the conference called "Rhogam."

Another exhibit which will be on display is "Perinatal Pathology" by Arch Brown, M.D., of Flint.

There is no registration fee for the conference and all physicians and interested persons are invited. A complete program of speakers and topics may be obtained from MSMS headquarters, P.O. Box 152, East Lansing.

MEDISCENE

March 6 — The Council, MSMS Headquarters, East Lansing

March 12 — State Woman's Auxiliary Legislative Day, MSMS Headquarters, East Lansing

March 13-14 — Annual meeting of the Michigan Academy of General Practice, Sheraton-Cadillac Hotel, Detroit

March 17-23 — National Poison Prevention Week

March 26-27 — Seventh Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 1 — 47th Annual Beaumont Lecture by Jose M. Delgado, M.D., Wayne State Medical Society Headquarters, Detroit, 8 p.m.

April 17 — The Council, MSMS Headquarters, East Lansing

April 21 — Eleventh Educational Seminar of MSMAS, Pick Durant Hotel, Flint

April 22-25 — Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28 — 17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, M.S.U., East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 8-10 — Michigan Public Health Association, Inc., Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 10-11-12 — 9th Annual Congress of the Professions (MAP), Boyne Highlands

May 15-18 — International Science Fair, Detroit

May 18 — Kresge Eye Institute Clinic Day, Detroit

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 28-29 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26-27 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 11-15 — American Public Health Association, Cobo Hall, Detroit

WSU TO OFFER SYMPOSIUM SOON ON ALCOHOL METABOLISM

A symposium on "Biochemical and Clinical Aspects of Alcohol Metabolism" will be sponsored April 11 and 12 by the Wayne State University School of Medicine. The two-day program will be held at the headquarters of the Wayne County Medical Society, 1010 Antietam.

Twenty five presentations will be made by physicians and scientists from 17 universities, laboratories, and hospitals in the United States and Canada.

In addition to seven clinical studies, the program will cover: determination of alcohol, alcohol dehydrogenase, metabolic effects of alcohol (experimental) and effects of alcohol on tissues and organs.

OTTAWA SPONSORS SERIES OF PUBLIC SEMINARS

The last in a series of three public medical forums sponsored by the Ottawa County Medical Society is scheduled for April 23 at the Holland Civic Center.

C. Mark Vasu, M.D., of Grand Rapids, will serve as moderator on the topic of "Medical Emergencies."

After the formal presentation, specialists in various fields will answer questions from the audience.

The first public forum in the series was on "Cancer," January 23. The second discussed "Heart Disease and High Blood Pressure," February 27.

The Year Ahead

In making an appeal for auxiliary members to recruit new members and to increase their participation, Mrs. Stanley J. Roman, President of the Woman's Auxiliary to the Wayne County Medical Society, wrote some thought-starter copy in a recent issue of the *Detroit Medical News.*

In part, Mrs. Roman said to the auxiliary members:

"We must respond as a unified group to the needs and problems of the medical profession which exist as a result of ever changing times.

"Today medicine is buffeted on all sides from the rocky shoals of public criticism to the turbulent waters of federal legislation.

"To allay this buffeting and thereby create a better public image, concerted effort will have to be drafted and inducted more than heretofore.

"We should listen to the advice and suggestions of lay people, but respond willingly, by clarifying, interpreting and expressing the philosophy and ethics of a profession whose purpose lies solely in being of service to the minds and bodies of all."

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Judicial Commission To Elect Officers Soon

The MSMS Judicial Commission, which met recently with three new members, will meet on April 17 to elect officers for 1968-69.

Robert H. Hamburg, M.D., Detroit, and W. H. Huron, M.D., Iron Mountain, both newly-elected to the Judicial Commission, were present at the last Commission meeting at MSMS.

Also present was Norbert W. Scholle, M.D., Muskegon, who was appointed to fill the vacancy created by the resignation of Carl B. Beeman, M.D., Grand Rapids. Doctor Scholle was appointed to serve until the next election of judicial commissioners.

At the meeting, Chairman Donald N. Sweeny, Jr., M.D., Detroit, was authorized to appoint a special subcommittee to evaluate and make recommendations for possible improvements in the present appeal procedures to the commission in matters of ethics and grievances.

EASTER SEAL CAMPAIGN TO BEGIN MARCH 1

Crippled children and adults in all 50 states, Puerto Rico, and the District of Columbia, will be given treatment and rehabilitation as a result of the 1968 Easter Seal Campaign which begins on March 1 and ends April 14, Easter Sunday.

Sumner G. Whittier, former executive director of Michigan Medical Service, who is the present executive director of the National Society for Chippled Children and Adults, reports that last year nearly a quarter million handicapped persons received help from the Easter Seal societies.

The annual Easter Seal campaign is the Society's main source of income. Funds contributed at that time will support some 2,000 facilities and other Easter Seal Society programs.

PLAN PHYSICIAN-HOSPITAL CONFERENCE FOR MAY

MSMS will cooperate with the Michigan Hospital Association and several other organizations in the sponsorship of a spring meeting to discuss physician-hospital relations. The meeting for hospital administrators, hospital trustees, and physicians, is the outgrowth of a similar meeting sponsored last year by MHA on relations between medical staffs and trustees.

Leo W. Walker, M.D., Lansing, represented MSMS at the first planning meeting. The program is tentatively May 8-11 at Boyne Mountain.

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Say you saw it in Michigan Medicine

GURDJIAN AMONG SPEAKERS FOR WSU CENTENNIAL SEMINAR ON DIMENSIONS

The Wayne State University Centennial symposium, May 6-10, will focus on "Technology and the City: Human and Social Dimensions." This symposium will explore the implications for the individual and groups of the city considered as a concentration of the human functions of communication, transport, and energy.

One of the speakers will be Elisha S. Gurdjian, M.D., chairman, department of neurosurgery, WSU School of Medicine, professor of neurosurgery in engineering mechanics, and director of the WSU biomechanics research center.

Among the other speakers will be William O. Baker, Ph.D., vice-president for research, Bell Telephone Laboratories, J. E. Goldman, Ph.D., director, scientific research laboratories, Ford Motor Company; and Professor B. F. Skinner from Harvard University.

The final symposium in the Centennial series is "The City of Man: The University and Urban Culture," May 15-17.

A group of 100 of Detroit's most distinguished civic leaders, with Mayor Jerome P. Cavanagh and Governor Romney as Honorary Chairmen, are planning a civic banquet for June 13, 1968, as a salute from the City of Detroit to Wayne State, timed to coincide with the 100th Anniversary date of the issuance of the charter to the first of Wayne's colleges, the School of Medicine.

WANT TO TOUR AMA?

Planning to be in Chicago in the forseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

Booklet by Michigan Board of Education Reports MSMS Aids

The State Board of Education has published a new booklet which includes MSMS as a resource organization for schools who want help in setting up educational programs relating to health.

Called "Resource Guide for Health, Physical Education, Recreation and Outdoor Education," the booklet also lists 22 other governmental, professional, and voluntary organizations which stand ready to help schools develop programs relating to accident prevention, smoking, use of alcoholic beverages, drug abuse, growth and development, family life and sex education, physical fitness, and many others.

The booklet was prepared by the State Educational Planning Council for School Health Education, Physical Education, Outdoor Education and Recreation. Members of the Council include several MSMS physicians who represent various organizations: Eleanor Skufis, M.D., Adrian, from MSMS; Fred Moench, M.D., Midland, from the Michigan Health Officers Association; William H. Kelly, M.D., Lansing, Michigan Department of Mental Health; and Marshall J. Blondy, M.D., Detroit, Wayne County Medical Society.

On the page about MSMS, the state booklet describes the following MSMS objectives: "To encourage and assist educational institutions to carry out general and specific health educational programs and activities; To provide authentic, accurate information to students, teachers, and parents."

The booklet reports that the following committees are concerned about various aspects of child and school health: Child Welfare, Diabetes, Maternal Health, Family Life Education, Mental Health, Public Health, Public Relations, Rural Medical Services, Venereal Disease Control, Alcoholism and Drug Addiction, Disaster Medical Care, Eye Care, Medical Aspects of Organized Athletics, and Rehabilitation.

FUTURE AMA CONVENTIONS:

Sites and dates for future conventions will be:

ANNUAL	
1968	San Francisco, June 16-20
1969	New York, July 13-17
1970	Chicago, June 21-25
1971	Atlantic City, June 20-24
1972	San Francisco, June 18-22
1973	New York, July 15-19
1974	Chicago, June 16-20
CLINICAL	
1968	Miami Beach, December 1-4
1969	Denver, Nov. 30-Dec. 3
1970	Boston, Nov. 29-Dec. 2

ACTIVITIES, PROJECTS

10,000 Medi-Labels Recently Distributed

Since December 1, over 10,000 Medi-Labels have been mailed to private physicians and medical directors of automobile plants.

MSMS now is developing plans with some lay groups to authorize their distribution, but want it clearly understood that all information on the Medi-Label must be affixed to the sticker by the physician.

ABELL, WALKER, KNIGHTS LEAD STATE PATHOLOGISTS

President of the Michigan Society for Pathologists for the coming year is Murray Abell, M.D., professor of pathology, University of Michigan School of Medicine. President-elect is Leo Walker, M.D., director of laboratories, St. Lawrence Hospital, Lansing. Edwin Knights, Jr., M.D., Lansing, was re-elected secretary-treasurer.

At the recent annual meeting, the eighth annual Carl V. Weller Lecture was delivered by Frank Hartman, M.D., former director of the department of pathology at Henry Ford Hospital and currently medical research advisor, Office of Surgeon General in Washington, D. C. Doctor Hartman's talk dealt with the topic "Informed Consent in Human Experimentation."

The annual meeting also featured a seminar on "Tumors of the Breast" conducted by Harold Oberman, M.D., associate professor of pathology, University of Michigan School of Medicine.

Sees Need to Graduate Many More Physicians

American universities should be graduating at least 1,200 more doctors each year than are actually being produced, Dean William N. Hubbard Jr., M.D. of the University of Michigan Medical School, has often declared.

"It is highly probable that the figure might well be closer to 2,000," he says. "Throughout the United States and the halls of Congress there is a notable lack of the boldness and determination needed to increase the number of physicians in our country."

Urges Continuing Use Of Iodized Salt in State

"If this workshop were held 45 years ago, the discussions presented would have, undoubtedly, centered around the overwhelming incidence of endemic goiter in the State of Michigan, when nearly 40% of all school children examined were found to have enlargement of their thyroid glands due to iodine starvation," said Harry A. Towsley, M.D., Chairman of the Department of Postgraduate Medicine at the University of Michigan Medical Center, in a talk on "Goiter in Michigan" at the recent Seventh Annual Thyroid Workshop, sponsored by the Wayne State University School of Medicine and Detroit General Hospital, in Detroit.

Doctor Towsley outlined the fight against goiter by recalling the work of a committee in 1922 which had been appointed by the Pediatric Section of MSMS to study the problem.

Studies indicated that Michigan soil and water contained only slight quantities of iodine. After discussion, the committee concluded that addition of iodine to table salt would be the most effective solution to the problem, even though this method had been used and abandoned in Europe.

MSMS, the Salt Distributors Association, the Michigan Health Department, and William J. Hale, a well-known Midland chemist, worked together to develop a salt containing a minimum of "0.01% and maximum of 0.02%" iodine, which could be used in all table and cooking salt. In the spring of 1924, iodized salt was on the market. Then followed an educational effort on the part of the committee, the press, and nearly 200 MSMS members "which probably has been unequalled in intensity or success by any organized medical group," said Doctor Towsley.

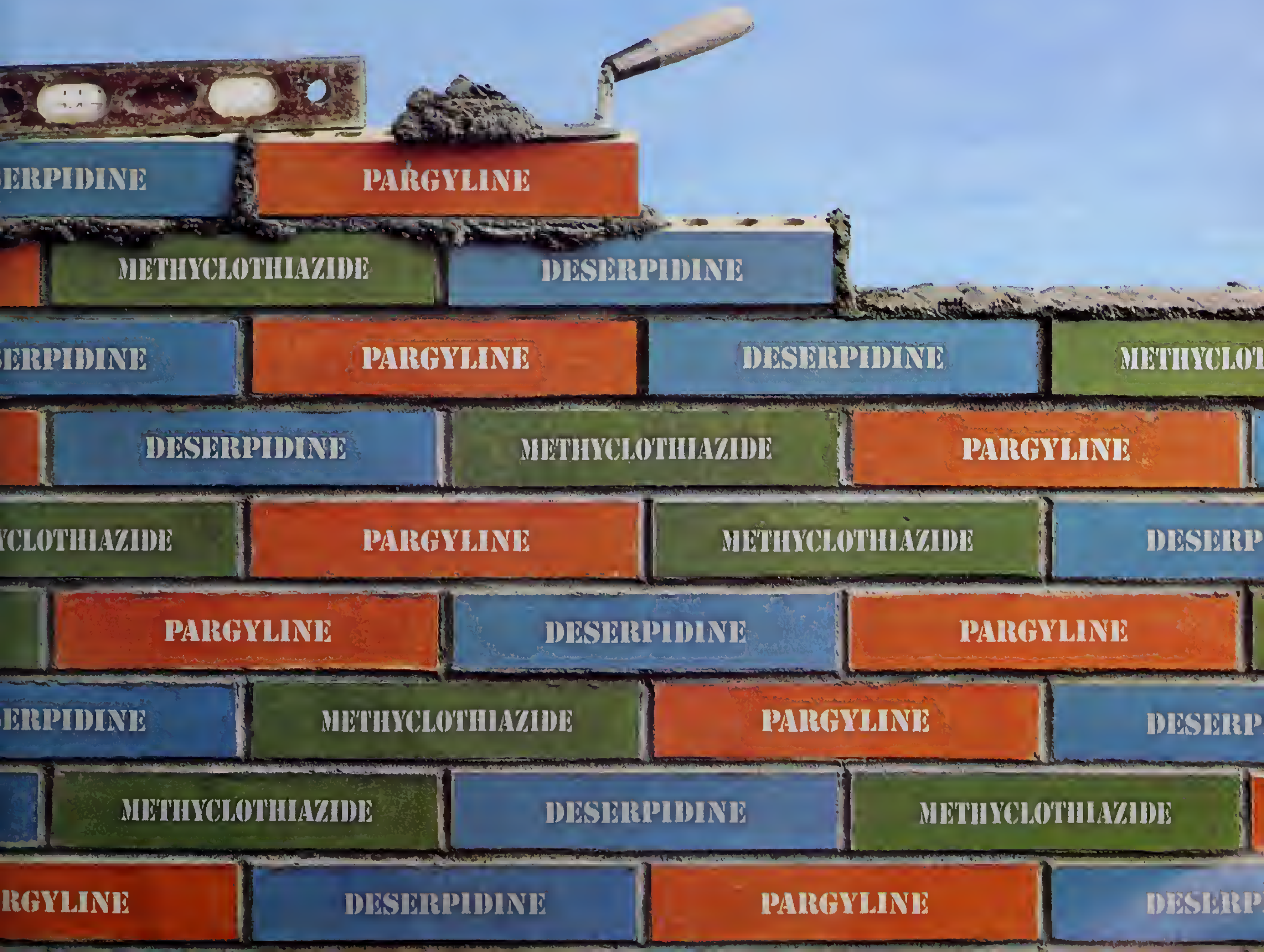
Ten years later, a survey showed a marked reduction of goiter in Michigan school children.

There has been a continuing decline, but at the same time "There is very substantial evidence that the need for continuing public education in the use of iodine-containing salt is essential," Doctor Towsley continued.

"The Iodized Salt Committee of the Michigan State Medical Society has, on frequent occasions, promoted the establishment of legislation comparable to that in Canada and some European countries, requiring iodization of all salt for human and animal consumption," Doctor Towsley concluded. "Such legislation has not been forthcoming and until it does, it is the responsibility of every physician in Michigan to insist that his patients continue to use iodized salt for the prevention of endemic goiter."

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
100 No. 6812
ENDURON
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na$^+$ output, yet easy on the K$^+$

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

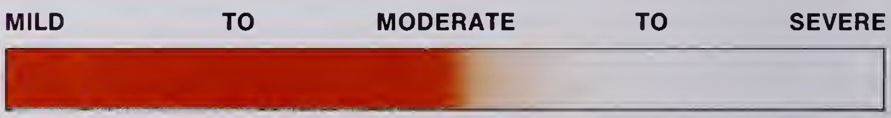
Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE


MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension

DESERPIDINE
METHYCLOTHIAZIDE
100 Tablets (Grooved) No. 6838
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

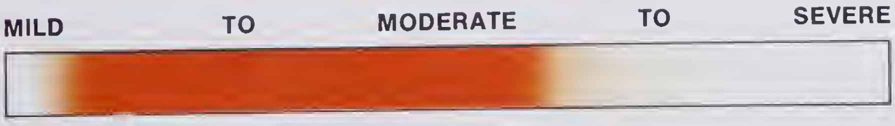
Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.


MILD
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Once a day, every day

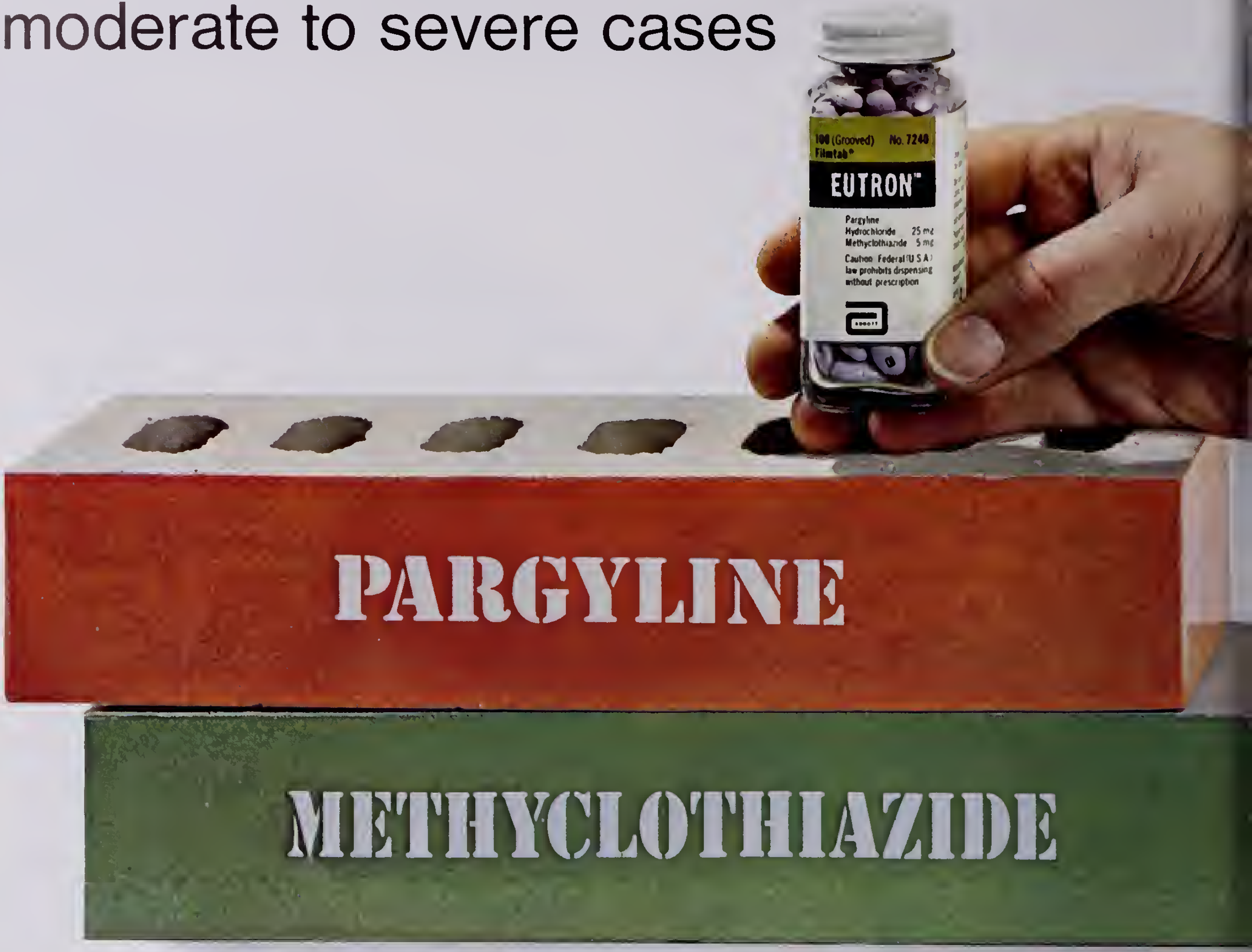
ENDURONYL

METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON™
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.) law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

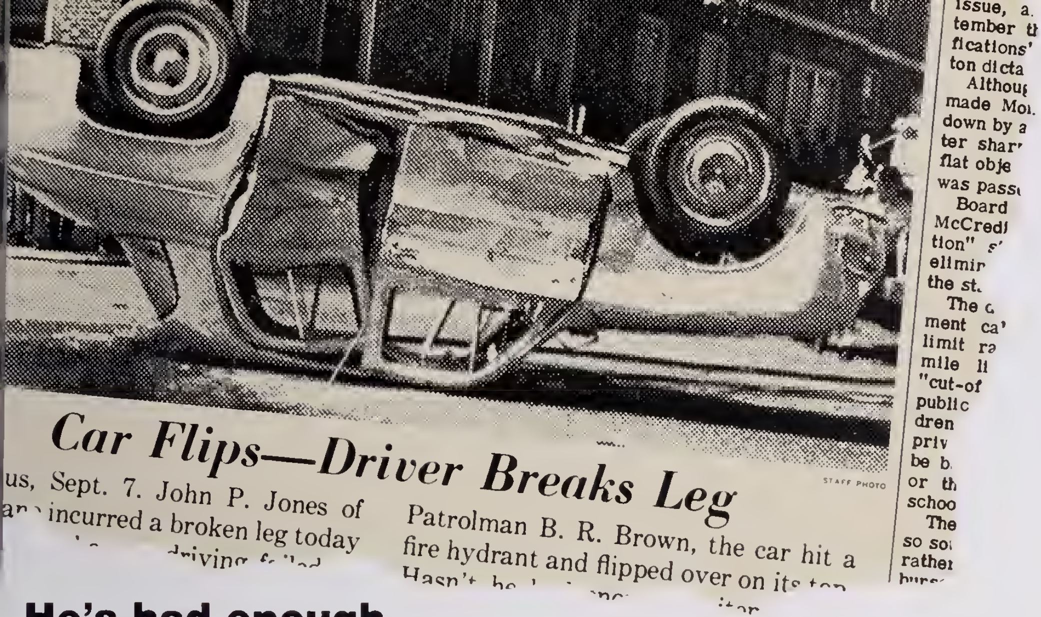
EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094



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Car Flips—Driver Breaks Leg

STAFF PHOTO

us, Sept. 7. John P. Jones of
an incurred a broken leg today

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

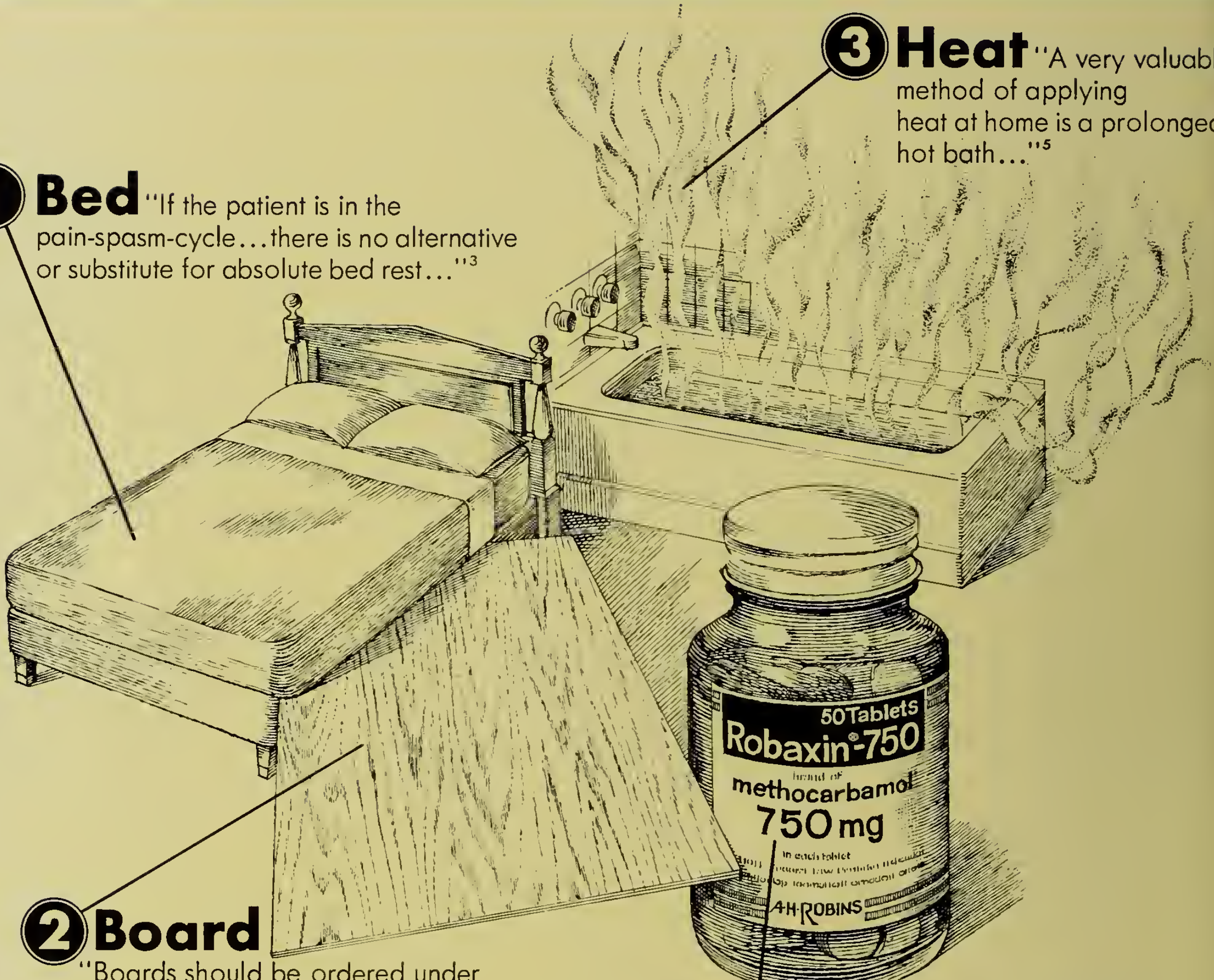
Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220
A-H-ROBINS

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



③ Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

④ Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) **References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS
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RICHMOND, VIRGINIA 23220

U-M CLINICAL RESEARCH UNIT GETS NEW GRANT

To continue its work of caring for some 500 patients each year, the U.S. Public Health Service has awarded $751,639 to the Clinical Research Unit at the University of Michigan Medical Center.

Medical school faculty members have conducted nearly 100 research projects since the 20-bed unit opened in 1962, thereby not only giving care to hundreds of patients, but also adding to medical knowledge.

During 1967, the unit cared for 517 patients and the staff was involved in 40 research projects.

SEARLE STEPS UP EDUCATIONAL SERVICES

Samuel N. Turiel has begun duties as Director of the newly-created Department of Professional Education at G. D. Searle & Company, Chicago.

The department will develop a nucleus of physicians and scientists to serve as both an educational advisory board, as well as available faculty for symposia and continuing medical education programs in a wide range of specified diagnostic and therapeutic areas of medicine. These special programs and symposia will be made available for use by directors of medical education at hospitals in addition to interested medical societies.

Meet the Members of The MSMS Council

Members of the MSMS Council and the MSMS officers took time out from the December meeting to pose for their annual official photograph. Shown on the steps of the MSMS Headquarters are, left to right:

Front row — Treasurer John R. Ylvisaker, M.D., Pontiac; Secretary Kenneth H. Johnson, M.D., Lansing; Council Vice-Chairman Ross V. Taylor, M.D., Jackson; President-Elect James J. Lightbody, M.D., Detroit; Council Chairman Robert J. Mason, M.D., Birmingham; President Bradley M. Harris, M.D., Ypsilanti; Past President Luther R. Leader, M.D., Royal Oak; Councilor Robert K. Whiteley, M.D., Grosse Pointe; Past President C. Allen Payne, M.D., Grand Rapids;

Second row — Councilor Ralph R. Cooper, M.D., Detroit; Vice-Speaker Vernon V. Bass, M.D., Saginaw; Councilor Don W. McLean, M.D., Detroit; Councilor John J. Coury, M.D., Port Huron; Councilor Robert V. Daugharty, M.D., Cadillac; Councilor Harold H. Hiscock, M.D., Flint; Councilor Harold F. Falls, M.D., Ann Arbor; Councilor Brooker L. Masters, M.D., Fremont;

Back row — Councilor Edward H. Rodda, M.D., Bay City; Councilor Sidney Adler, M.D., Detroit; Councilor J. Robert Franck, Jr., Wakefield; Councilor John R. Pedden, M.D., Grand Rapids; Councilor A. Carl Stander, M.D., Saginaw; Councilor Harvey C. Hansen, M.D., Battle Creek; Speaker James B. Blodgett, M.D., Detroit; Councilor Don Marshall, M.D., Kalamazoo.

Doctor Leader is chairman of the MSMS delegation to the AMA. Not included in the photo are Councilor Milton R. Weed, M.D., Detroit, and Councilor Eugene R. Elzinga, M.D., Marquette.

Florida Professor Named Chairman of New MSU Human Development Department

The MSU College of Human Medicine has established a department of human development with a prominent Florida pediatrician as its chairman. The appointment of William B. Weil, M.D., currently A. I. duPont professor for handicapped children at the University of Florida, is effective Aug. 1, 1968.

The new department will be responsible for the first year of the human biology sequence.

Secretary-treasurer of the Society for Pediatric Research, Doctor Weil was appointed at Florida as an associate professor of pediatrics in 1963 and to his present position in 1965.

Previous appointments held by Dr. Weil include that of assistant professor of pediatrics at Western Reserve University; associate pediatrician with University Hospitals of Cleveland, special postdoctoral fellow at Cambridge University, England, and public health postdoctoral fellow and Harvard research fellow at Harvard University

He received his M.D. in 1948 at the University of Minnesota.

MOON TO SUPERVISE BALDWIN OEO PROJECT

William W. Moon, M.D., of Cadillac, has recently been named medical director of a comprehensive neighborhood health services program for low-income rural residents located in Lake county, and portions of Newaygo, Mason, and Manistee counties.

Funded by a $942,713 grant from the federal Office of Economic Opportunity, the program combines the effects of the State Department of Public Health, Michigan State University's College of Human Medicine, and Five-Cap, Inc., the local OEO organization.

Doctor Moon has practiced in Cadillac as a general practitioner since 1951.

U-M GRAD DIRECTS NIMH

James D. Isbister has been appointed executive officer of the National Institute of Mental Health, a bureau of the U.S. Public Health Service. Mr. Isbister received his B.A. from the University of Michigan in 1958, and his M.A. from George Washington University in 1966. He has received the Regents Alumni Honor Award from the University of Michigan.

Prior to joining NIMH, Mr. Isbister was Executive Officer of the National Library of Medicine from 1965 until his new appointment.

MOYER, NINE OTHERS CITED BY MAGAZINE

Carl A. Moyer, M.D., Houghton, recently was named by *Modern Medicine* among 10 recipients of its 1968 Awards for Distinguished Achievement. Doctor Moyer, professor of biological sciences and director of research at Michigan Technological University, was cited for his research in burn therapy leading to more effective management of extensive burns.

One of Doctor Moyer's current projects is a program wherein the six counties of the Michigan Upper Peninsula and Michigan State University have joined forces to provide comprehensive health care to the area and to train medical and other health profession students. He is director of the heart-cancer-stroke project of the plan and has been named professor of medicine, on a voluntary basis, by MSU.

JACKSON AUXILIARY HOLDS SEMINAR ON CAREERS

School principals and counselors in Jackson County recently learned more about job opportunities in the medical field, through the efforts of the Woman's Auxiliary to the Jackson County Medical Society.

A seminar at Foote Hospital featured a panel of representatives from various health careers. Richard K. Waeschle, M.D., represented medicine on the panel, which was moderated by the health counselor at the community college.

"Horizons Unlimited," a movie produced by the AMA was shown, and, following dinner, talks were given by Robert E. Kinsinger, educational director of the W. K. Kellogg Foundation, and John A. Doherty, executive director of the Michigan Health Council.

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

ANNOUNCE PROMOTIONS AT PARKE-DAVIS

The Board of Directors of Parke, Davis & Company has made a broad realignment of the company's top operating management.

Austin Smith, M.D., Chairman of the Board and Chief Executive Officer, has been named to the office of President, formerly held by Harold W. Burrows, who retired December 31.

C. D. Smith, Executive Vice President, becomes a member of the Board's Executive Committee, and will act as its secretary.

William G. Meier, who has been Vice President, Production and Engineering, was appointed Administrative Vice President.

L. M. Lueck, formerly Director of Quality Control, has been elevated to Vice President for Quality Control and Government Relations.

Joseph F. Sadusk, Jr., M.D., who has been Vice President for Medical Affairs, was named Vice President for Medical and Scientific Affairs.

Carl Johnson was appointed Vice President for Corporate and Community Relations. He has been Vice President, Advertising and Public Relations.

L. A. Sweet, formerly Vice President, Research, has been named Vice President for Research Development and Application, a newly-created office.

"The new alignment places continued strong emphasis on our research, quality control and medical affairs, and broadens the administrative responsibilities for the renewed growth period ahead," the Board said.

Doctor Smith, 55, joined Parke-Davis in December, 1965, as a member of the firm's Board of Directors, and on January 1, 1966, became Vice Chairman of the Board. A year ago, he was elected Chairman. Between 1959 and when he joined Parke-Davis, Dr. Smith served as President and Chief Executive Officer of the Pharmaceutical Manufacturers Association, and before that was editor of the American Medical Association Journal.

Doctor Sadusk, 58, joined Parke-Davis last April 1 from the Johns Hopkins University School of Medicine where he had been professor of Medicine and associate dean. He has held numerous faculty positions at medical schools around the country and also served as medical director for the Food and Drug Administration.

CORSSEN TO ALABAMA

Guenter Corssen, M.D., University of Michigan professor of anesthesiology, will leave the U-M faculty in April to become chairman of the department of anesthesiology at the University of Alabama Medical Center, Birmingham.

VISIT A 19th CENTURY
ONE MAN CLINIC

and the panorama of American History at Henry Ford Museum and Greenfield Village. See the office of Dr. Alonson Howard . . physician, surgeon, dentist, chemist, apothecary . . . the classical example of the country doctor. Plan a family adventure today. Stay at the Dearborn Inn, only 700 yards from the museum and its unmatched mechanical and fine arts collection. May we send our brochure.

180 thoroughly modern guest rooms in the Inn, Colonial Homes, Motor House from $13 single, $18 double. Two restaurants, cocktail lounge.

The Dearborn Inn

OAKWOOD BLVD. DEARBORN, MICHIGAN 48123 (Area 313) 271-2700

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ-

When a milestone in life is marred by depression...

Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride
Geigy

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5 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

The helicopter ambulance brings in a patient to the University Hospital. Ground attendants (foreground) have come to meet the helicopter with stretchers and blankets.

HELICOPTER AMBULANCE SERVICE STARTED

BY PETER HOHEISEL
OF THE MSMS STAFF

One recent day, luncheon patrons of the Wyandotte Yacht Club on the Detroit river were surprised when a small helicopter whirled out of the blue sky and gently touched down on the snow covered lawn between the Yacht Club and the river.

The performance was designed for C. Mark Vasu, M.D., chairman of the emergency medical services committee of Kent County Medical Society, and several Grand Rapids city officials who were conferring with managers of Superior Ambulance Service in Wyandotte about ambulance service as part of total emergency care.

The helicopter, a Bell Ranger 47-J, has been in use by the company since the middle of December; it is the first time a private company has relied upon a helicopter as an ambulance vehicle.

Superior owns one helicopter. Another is available on a contract basis from a Detroit area aviation organization.

"The land ambulance is still primary, but we feel helicopters can perform an invaluable back up service, especially for certain cases," explains Walter Gutowski, president of Superior Ambulance Service.

"For example, in our first case we transferred a severely burned patient from Wayne County General Hospital to the Intensive Burn Care Unit at Ann Arbor in 16 minutes," Mr. Gutowski continued.

"A land run at a similar time of day would have taken about 45 minutes. The man had a progressive, chemical burn and every minute we could save in getting him to Ann Arbor was vitally important," Mr. Gutowski said.

With its home base at National Airport in Westland, the Ranger is now ready to provide emergency transportation within a 100-mile-radius of Ann Arbor. University of Michigan has plans to blacktop, fence, and light a landing pad which is only 100 yards from the emergency room entrance.

Cases most apt to benefit from the service are head injuries, severe burns, and spinal injuries.

The Ranger can carry two litters inside the cab. It has two kits — a standard doctor's bag and a first aid kit. Cruising at 90 mph, the helicopter can carry two patients and a pilot or a patient, attendant, and pilot.

"With its night-flying equipment and our capability of flying in almost any weather, with the exception of icy conditions, our service provides dependable emergency transportation," explains Philip Nelson, an operational manager at Superior Ambulance.

"The appeal for doctors," Mr. Nelson said, "is that it reduces liability. The physician who first sees an emergency patient is responsible, in case of transfer, until that patient is in another doctor's care."

"The physician who must transfer a patient is concerned with speed, smooth transferal, and a trained attendant to look after the person," Mr. Nelson continued. "The helicopter can cut the time from emergency room to emergency room by about 70%. The patient is in a controlled environment and he has a smooth ride."

"Good emergency medical care," Doctor Vasu continued, "involves first aid and rescue, communication, transportation, and emergency facilities. Emergency facilities will include all the necessary equipment plus training for the people who are in first contact with the injured person."

Totally efficient emergency medical care throughout the state is at present a dream. In fact, with funeral directors going out of the ambulance business, gaps are showing up.

The helicopter will not answer the problem of decline in land ambulance service because it cannot do the job of a land ambulance. It promises, nevertheless, to be a valuable tool in meeting some of the problems in the field of emergency medical care.

NINE MICHIGAN MEN JOIN AMA COMMITTEES

Nine Michigan men are among those named to membership on AMA councils and committees. The appointments, which were approved by the AMA Board of Trustees, are for a term of one year with a maximum tenure of 10 consecutive terms.

The AMA reports that Bertram D. Dinman, M.D., Ann Arbor, was appointed to the Committee on Ocupational Toxicology. Reappointed to committees were: Roger G. Hansen Ph.D., East Lansing, Council on Foods and Nutrition; Herbert A. Raskin, M.D., Detroit, and Maurice H. Seevers, M.D., Ann Arbor, Committee on Alcoholism and Drug Dependence; Starling D. Steiner, M.D., Detroit, Council on Occupational Health; Richard C. Schneider, M.D., Ann Arbor, Committee on Medical Aspects of Sports; Alexander H. Hirschfeld, M.D., Detroit, Joint Committee on Mental Health in Industry. Donald J. Birmingham, M.D., Detroit, was reappointed to the Committee on Rating of Mental and Physical Impairment and reappointed chairman of the Subcommittee on Skin; John W. Rebuck, M.D., Detroit was reappointed to the Subcommittee on Hematopoietic and Lymphatic Systems.

The AMA reports that William D. Robinson, M.D., Ann Arbor, has retired from the Council on Foods and Nutrition; and Charles G. Child, III, M.D., Ann Arbor, from the Committee on Nursing.

In addition to the above Michigan men who have been appointed by the AMA Board of Trustees, George W. Slagle, M.D., of Battle Creek, serves as chairman of the AMA Council on Medical Service. He was elected to the Council by the AMA House of Delegates.

NEERKIN GIVEN AWARD FOR SAVING BOY'S LIFE

A. J. Neerken, M.D., Kalamazoo, has been honored by the Carnegie Hero Fund Commission of Pittsburgh, Pa., for saving a 16-year-old boy's life.

On December 26, 1965, Doctor Neerken saw two boys fall through thin ice on Woods Lake. One of the boys drowned but Doctor Neerken, himself going through the inch-thick ice, was able to keep Richard Fish afloat until Kalamazoo firemen rescued them both.

The belated award is a bronze medal.

Auxiliary Members Help In Legislative Arena

BY MRS. W. G. GAMBLE, JR., BAY CITY
PRESIDENT, WOMAN'S AUXILIARY

The Auxiliary is organized to assist MSMS in its legislative activities — we are at your service, awaiting your call to action! Auxiliary members are available to contact legislators about issues vital to the medical profession.

To further its members' knowledge about legislation, the Auxiliary will hold, for the first time, a "Legislative Day." Scheduled for March 12 in Lansing, state officers and presidents, presidents-elect, and legislative chairmen from all county medical auxiliaries will be invited to this special event.

On the day's agenda will be briefings about current topics such as the impending chiropractic bill (Senate Bill 227), Michigan's Basic Science Law (Senate Bill 229), etc., a film, "The People of Michigan Enact" which illustrates the law-making procedure in Michigan, and, in the afternoon, a personal meeting of each Auxiliary member with her legislator.

MEMBERS OF THE Auxiliary also attended the recent Detroit meeting on "The Doctors, the Law, and the Courts," and, to keep abreast of current legislative matters, county legislative chairmen receive the *MSMS Medigram* and the *AMA Legislative Roundup*. Furthermore, Mrs. Donald S. Bolstad, Dearborn, State Auxiliary Legislative Chairman, is an exofficio member of the MSMS Legal Affairs Committee, and she reports MSMS legislative activities to Auxiliary members and enlists their aid.

Legislation is of vital concern to the profession of medicine — that no one will debate. However, doctors, being as busy as they are with professional duties, seldom have sufficient time to devote to "outside" activities such as legislation.

HOWEVER, THE AUXILIARY is available and ready to help. When the need arises to voice an opinion on a medical issue, Auxiliary members can contact their elected representatives by letter, telephone, or personal meeting.

Let us help you help others through legislation!

Group Elects Tryloff

Warren Tryloff, MSMS Associate Director, was recently re-elected treasurer of the Professional Convention Management Association. The election took place at the Joint Conference of Medical Conventions, a meeting of medical society convention managers and pharmaceutical convention managers for the discussion of mutual problems and interests.

Sustained circulatory, respirator
and cerebral stimulation for th

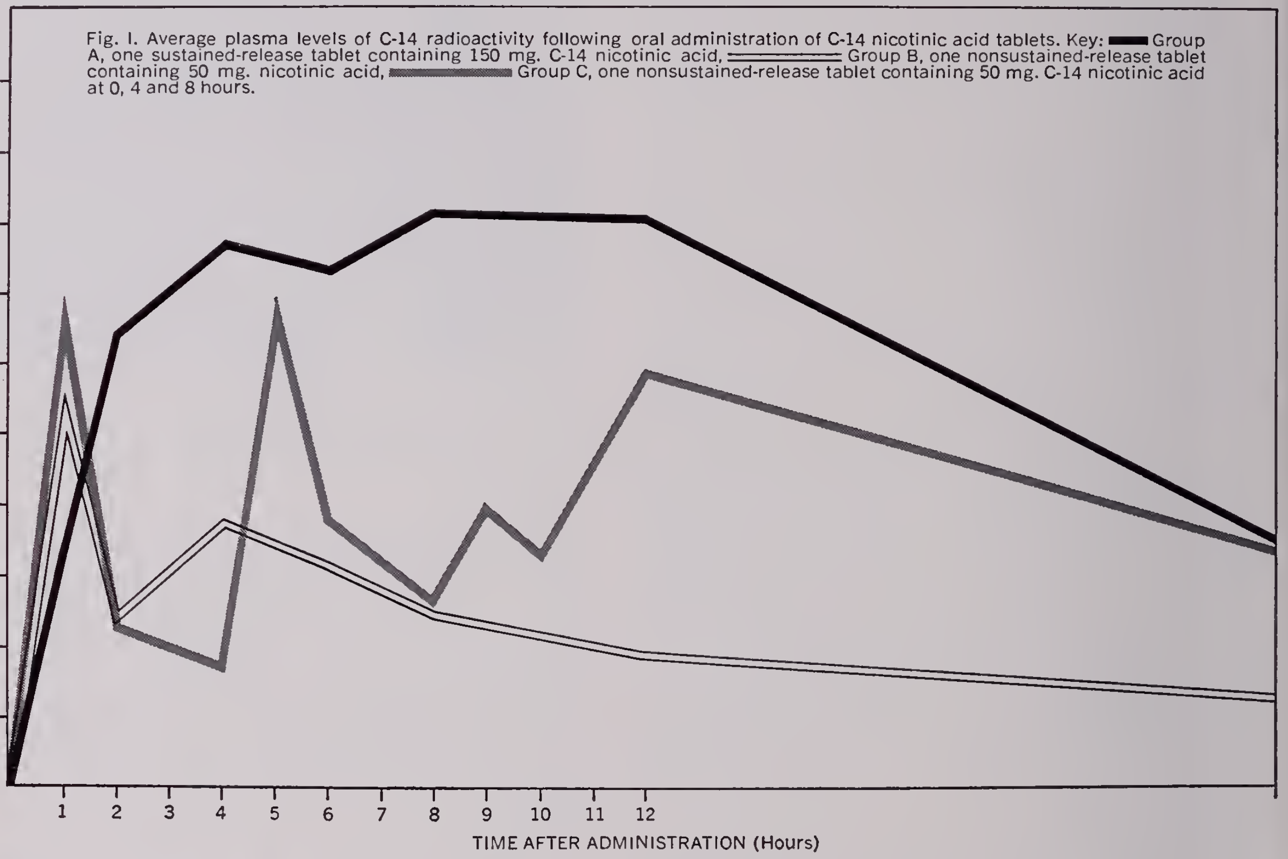

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

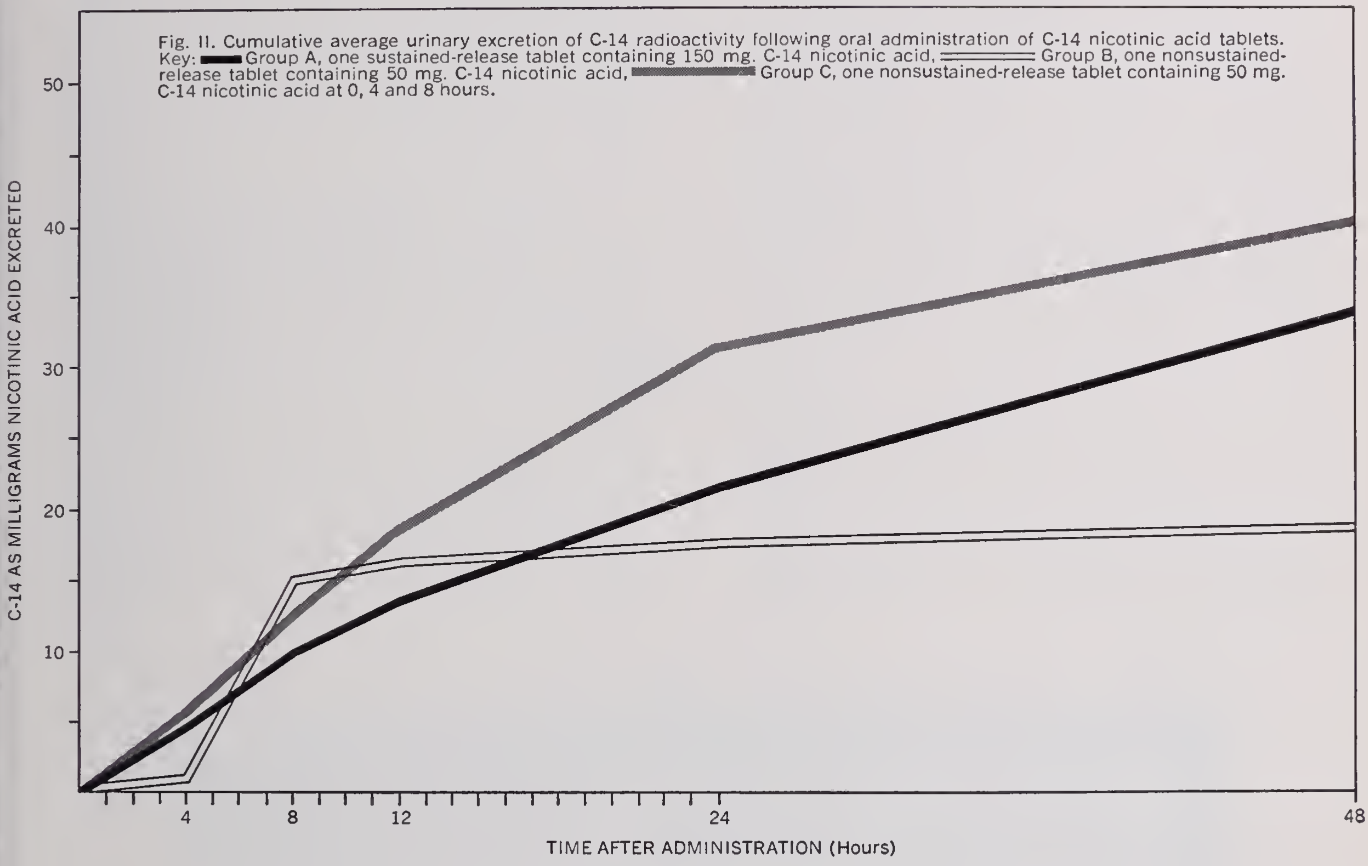

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

Michigan Influenza Outbreak Described

BY MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The epidemic of influenza A_2, which began in Michigan in October 1967 was virtually over by mid-January, except for a few sporadic cases. Every county of the state experienced an outbreak, although the severity of illness and the proportion of the populace that was ill varied quite a bit from place to place at the end of January.

Serologic confirmation of the outbreak of influenza A_2 by compliment fixation was made on specimens from 13 counties: Kalamazoo, Ingham, Calhoun, Washtenaw, Wayne, Kent, Marquette, Saginaw, Macomb, Barry, Genesee, St. Clair, and St. Joseph. More specimens from other counties are still being examined.

Typical outbreaks in any given place began in the high schools with a few cases of febrile respiratory illness followed about one week later by a sudden outbreak of typical influenza with absenteeism usually reaching 25-30% in the first days of the outbreak. Within one week the grade school children and adults would become ill, and by the end of the second week, only sporadic cases would still be occurring. The outbreak lasted longer in the larger cities.

School absenteeism usually was 25-30% on the peak days of the epidemic, although Traverse City reported 50% and Hesperia, in Newaygo county, reported 70%. Industrial absenteeism was slight.

Influenza first appeared at Western Michigan University in Kalamazoo in the 43rd week (October 22-28). The school children in Kalamazoo were also affected, and a week later, influenza appeared in Battle Creek in Calhoun County. Influenza next appeared in Lansing in the 46th week (November 12-18), just before the Thanksgiving vacation, when all the Michigan State University students went home for vacation. Following this, the disease spread much more rapidly in all directions, especially, to the north and east to the major population centers of Saginaw, Genesee, Wayne, Oakland, and Macomb counties. During the 50th week alone (December 10-16), the northern half of the Lower Peninsula experienced its epidemic, as well as much of the Upper Peninsula. During the remaining two weeks the epidemic moved westward across the Upper Peninsula.

The apparent jump of the illness from the Kalamazoo-Battle Creek areas to Lansing, and the more rapid dispersal from Lansing around Thanksgiving was possibly due to movements of college students on vacation and high school basketball games.

in the treatment of
IMPOTENCE
Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:
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THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO
PDR

Speech at MSMS Meeting Now in National Journal

The speech of C. Howard Ross, M.D., Ann Arbor, before the MSMS Conference on Medical News Reporting has been printed in *Medical Times.*

The address, entitled "The Evangelism of Communications," was the after-dinner speech at the 1965 Conference at MSU and the MSMS headquarters. Doctor Ross, president of Michigan Medical Writers Association, recalled some quotations from great medical and world figures. The article appeared in Vol. 95, No. 9 of *Medical Times.*

OFFER SCHOLARSHIPS TO ALCOHOL INSTITUTES

The Michigan Department of Public Health Alcoholism Program will offer 50 scholarships to participants at the Midwest Institute of Alcohol Studies and the Rutgers Summer School of Alcohol Studies.

The scholarships, limited to Michigan residents, provide tuition, room and board for concerned professional and lay people. Scholarships have also been given to Alcoholics Anonymous members in an effort to strengthen the relationship between A.A. and the helping professions.

Midwest Institute will be held at Northwestern University, Evanston, Illinois, June 16 through 21, 1968. The Rutgers Summer School will be held from June 30 through July 19, 1968, at Rutgers

Applications for scholarships may be secured from the Michigan State Department of Public Health Alcoholism Program, 3500 North Logan Street, Lansing, Michigan 48914.

Receive U.S. Grants

Two Wayne State University Medical School professors are recipients of recent U.S. Public Health Service grants. Gianfranco Dal Santo, M.D., Franklin, professor and chairman of anesthesiology in Wayne State's School of Medicine, was awarded $24,291 for a study of the dynamics of anesthetic agents. For continuation of research entitled "Biochemical Mechanisms of Tissue Repair," $22,657 went to Richard J. Bing, M.D., Birmingham, M.D., professor and chairman of the department of internal medicine.

DID YOU KNOW . . .

. . . that the current worth of chemicals in the human body has recently been quoted at $800 by scientific researchers? The value, once quoted at 98¢ has gone up due to the demand for enzymes and nucleic acids.

Easy on the Budget...
Easy on the Mother

Tablets & Elixir
For Iron Deficiency Anemia

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brand of FERROUS GLUCONATE

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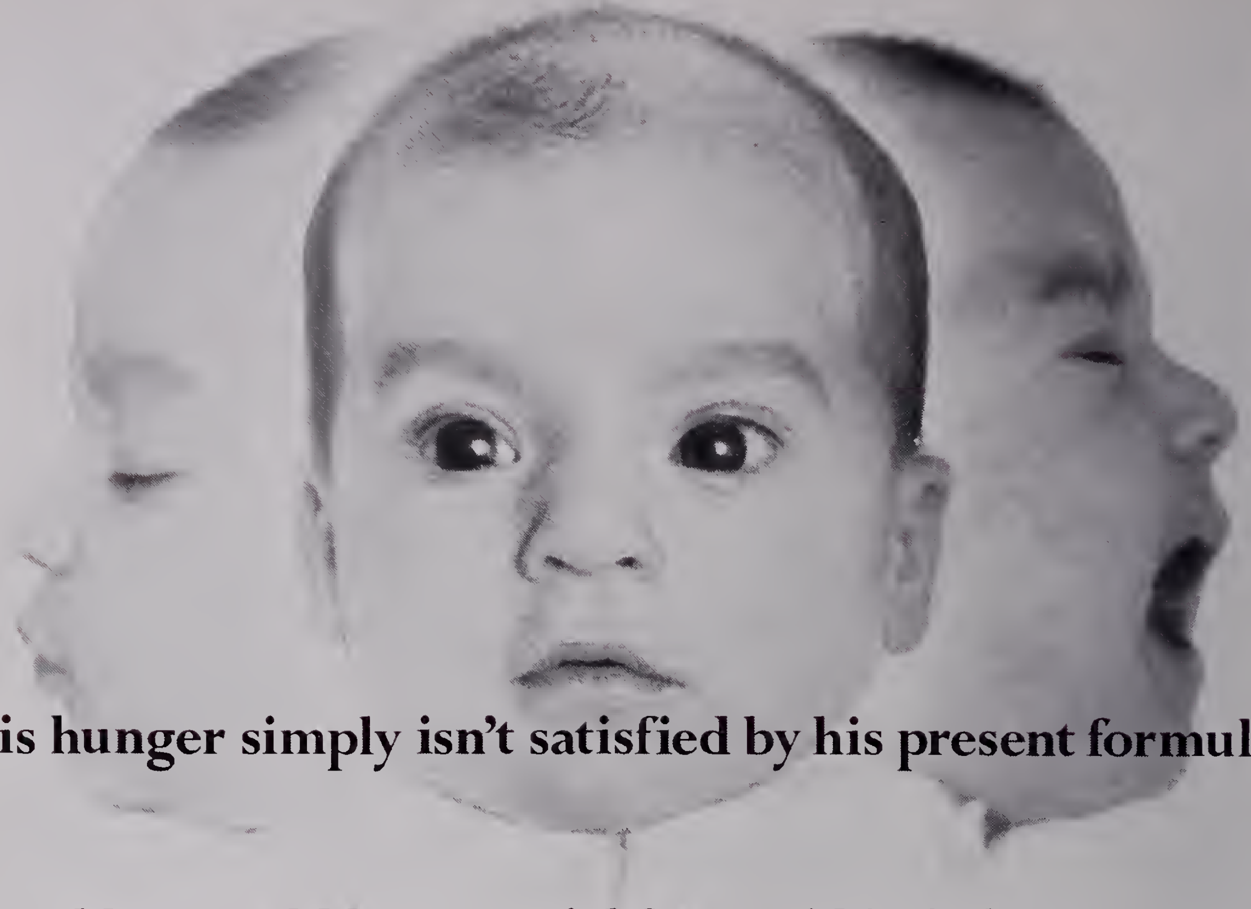


If his hunger simply isn't satisfied by his present formula…

the problem could be essential fatty acid imbalance

Excessive appetite, inordinate crying, poor weight gain and skin rashes can be caused by an infant formula that does not have fatty acid balance.[1-5] Linoleic acid is a required nutrient which is converted, in part, to metabolically-active arachidonic acid. Preliminary studies have shown that linolenic acid, if present in sufficient quantity, can adversely affect this conversion. Optimil has only trac amounts of linolenic acid.

Fat analyses of Optimil and two leading modified-milk formulas*

Fatty acids	Optimil % of fat	Prod. #2 % of fat	Prod. #3 % of fat
Saturated	**40.4**	**44.2**	**39.0**
Caprylic	3.3	1.6	2.2
Capric	2.2	1.1	1.5
Lauric	16.0	10.1	11.7
Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

* Mean of three lots tested

ptimil, an optimum-nutrition infant formula, helps reduce problems

feeding

ew Optimil from Carnation ntains more than enough linoleic cid and only a trace of linolenic. hus Optimil-fed infants maintain lequate tissue levels of achidonic acid. This is reflected the high caloric efficiency Optimil, and helps to satisfy inger and promote efficient eight gain and a clear complexion makes an infant contented.[6-8]

ecommend Optimil

or optimum contentment, ptimum digestibility and optimum rowth, recommend Optimil, the ptimum-nutrition infant formula. omes in the new full 16-fluid unce can for maximum onvenience in formula preparation. vailable only at drug stores.

in digestibility

Of all the fatty acids commonly found in infant formulas, stearic acid is the least digestible.[9] Optimil contains a comparatively low level of stearic acid and a relatively high level of oleic acid, which has been shown to aid in the absorption of stearic acid. Optimil also has a high ratio of unsaturated fat to saturated fat which further enhances the formula's digestibility.

in stooling

Stooling problems and perianal dermatitis are minimized by the presence of lactose. A low renal solute load assures ample expendable water reserves to meet stress situations. Adequate amounts of all-known essential vitamins and 8 mg. of iron are included per diluted quart.

1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

Optimil
Optimil

Optimil®, an optimum nutrition infant formula, from Carnation®

MAILBAG

I have noticed in your recent issues of *Michigan Medicine* repeated references to the AMA and its programs. Thank you for your efforts.

F. J. L. Blasingame, M.D.
AMA Executive Vive-President

Many United States doctors have given some of their time and talent to short term missionary type work in recent years. It is no longer a particularly unique endeavor. My message is therefore not one of a new discovery, but rather to endorse a seven-year-old project — S.S. Hope.

The ship was in Cartegena, Colombia from early February 1967 until December 8, 1967. From August 13 until October 15 they endured my presence aboard (and ashore). It is difficult for me to imagine a better vacation.

The ingredients of a satisfactory vacation were all there. The basic requirement is a change from the usual routine. The ship and the city provided that. In orthopedic surgery, as in most of the specialties, time was fairly evenly divided between the hospital ship itself and Hospital Santa Clara of Cartegena University Medical School. The organization and administration of the ship as a functioning hospital were virtually unblemished, but in many respects different from Saginaw General Hospital. It is no problem to practice good medicine aboard. Hospital Santa Clara, burdened with almost unbelievable financial problems, provided a fascinating experience in a different sort of practice.

People, however, are what really produce the perfection. The regular personnel (i.e., everybody except the doctors who rotate every two months as I did) are uniformly both delightful and competent. They practically whistle while they work. The nurses, lab technicians, X-ray technicians, dietitians, etc. are all highly selected people of great talent. In addition to that, it was my good fortune to be associated with the only native, orthopedic resident of Hospital Santa Clara. He is a very bright young man who fortunately had taught himself English sufficiently well that we could communicate quite easily. Had we depended on my Spanish, we'd have been reduced practically to salutations.

There was time for some sight seeing, some swimming (fantastic snorkeling in clear water with coral and tropical fish), a little golf, and other things to eliminate ennui. All in all it was the compleat vacation: enough work to feel useful, enough diversion to be interesting. No physician could spend two months better.

—John O. Goodsell, M.D.
Saginaw

The article in *Michigan Medicine* about the Midland Hospital program to help develop family practice physicians (September issue) has produced a rather surprising response. I have had quite a number of letters from around Michigan in response to the article and several from various places around the country as far as Texas and California in response to the article in the *AMA News*. I've received one inquiry from a young medical officer who gets out of the service next July who is interested in getting into this type of program.

A little publicity really goes a long way!

Thanks very much for all your interest and all your help.

Sincerely,

Robert E. Bowsher, M.D.
Director of Medical Education
Midland Hospital

On behalf of our City of Wayne Museum, and those who use our resources, we wish to thank you for the copy of *A Century of Service in Medicine* which we received recently.

This is a fine addition to our Michigan history, and a most attractive book.

Wayne City Historical Museum
Mildred Hanchett
Director

In Unity — Strength

"It is my conviction that harmony is essential to the overall effectiveness of our profession, both in public campaigns and in our principal objective of patient care. And harmony and active cooperation are necessary not only within our profession — among specialty groups, individual and group practitioners, educators, hospital-employed physicians; but also between physicians and all other members of the health team — dentists, nurses, allied professions and occupations, pharmacists and pharmaceutical manufacturers and personnel of the health insurance industry and the prepayment plans."

—Milford O. Rouse, M.D.
AMA President

Statute Is Quoted Regarding Info Sought On Birth, Death Reports

The new forms for births and deaths require physicians to provide additional information and some questions have been raised about the legality of such disclosures of confidential information.

The following is provided for MSMS members by the MSMS legal counsel:

"Due to an increased demand for statistical data in the socio-economic field from both the federal and state governments, the following statute is quoted:

" 'MSA, Sec. 14.57 (3), as amended, provides as follows:

Sec. 3. The furnishing of information, records, reports, statements, notes, memoranda or other data voluntarily to the state health commissioner or his authorized representative, or to any person, agency or organization duly designated as a medical research project, shall not subject any physician, hospital, sanatorium, rest home, nursing home or other person or agency furnishing such information, records, reports, statements, notes, memoranda or other data to liability in any action for damages or other relief, and shall not be deemed to be the wilful betrayal of a professional secret or the violation of any confidential relationship.' "

Thought Starters

Nothing can come out of an artist that is not in the man.

H. L. Mencken

Plans are the dreams of the reasonable.

Feuchtersleben

Freedom from the desire for an answer is essential to the understanding of a problem.

J. Krishnamurti

The worst tempered people I've ever met were people who knew they were wrong.

Wilson Mizner

Always imitate the behavior of the winners when you lose.

George Meredith

Unquestionably, there is progress. The average American now pays out twice as much in taxes as he formerly got in wages.

—Mencken

One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin .... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

Explains Why Professional And Public Liability Insurance is Needed

This article is reprinted with permission from Volume XI, No. 3 of The Doctor and The Law, published by the Student American Medical Association.

Generally speaking, malpractice, or professional liability, insurance obligates the company to pay damages for which the physician has become liable as a result of injury arising out of malpractice, error, or mistake in performing or failing to perform a professional service. General liability insurance, or casualty insurance, on the other hand, usually specifically excludes injuries due to the rendering of professional services. An injury to a patient in the physician's office may raise the question of which carrier must pay the damages. The physician will probably be reimbursed by one policy or the other but the companies themselves are vitally concerned as to which one must pay.

In *Hazard* v. *Aetna Casualty and Surety Company,* 253 F Supp. 845, the plaintiff, a polio victim, fell and injured himself when he shifted his position on a stool in a physician's treatment room. The question arose as to whether the physician's casualty insurance or his professional liability insurance covered the injuries sustained. The court got out of trouble by noting that if one thing is certain in this case it is that there is a gray area lying at the fringes of each policy where a given accident may be seen as the result of either the ordinary negligence of a property owner or the improper rendering of, or failure to render, professional care. The court said that in this case both insurance carriers were defending and that if damages are awarded "the court and jury will be able to determine, on the basis of all the evidence adduced at a full trial, exactly how the accident occured and whether the professional liability insurer or the public liability insurer or both are obligated to pay the judgement."

In a somewhat similar case *(American Policyholders Insurance Company* v. *Michota.* 103 NE2d 817) the professional liability carrier asked for a declaratory judgement as to its liability for a claim for injuries by a chiropodist's patient in a fall from a treatment chair. The patient fell when, in following the chiropodist's instruction, she attempted to sit in a metal hydraulic chair designed for the occupancy of patients. The chair was unlocked and it rotated suddenly, causing her to lose her balance. The policy in question covered injuries arising during the course of professional services, not just as a result of failure to exercise the proper standard of professional skill. Maintaining the treatment chair in a proper and safe condition for the accommodation of patients was a service or duty directly connected with the practice of the defendant's profession as a chiropodist. Since the relationship of doctor and patient was clearly established, the court held that the injury resulted from the rendering of a professional service.

The same reasoning was followed in *Messer* v. *Estate of Shannon,* 397 P 2d 846. An osteopath's casualty insurance policy excluded injuries due to malpractice error, negligence, or mistake committed in the performance or omission of a professional service. According to the evidence, the osteopath was giving the patient a manipulation at the time the accident occurred. It was apparently the result of a defective safety catch on the table. The table was especially designed for osteopathic treatments and it, therefore, constituted "professional equipment." The policy's exclusion of professional liability was not restricted to malpractice, the court pointed out. It also excluded liability for any negligence committed in the performance of "professional services." The casualty insurance carrier was found not liable.

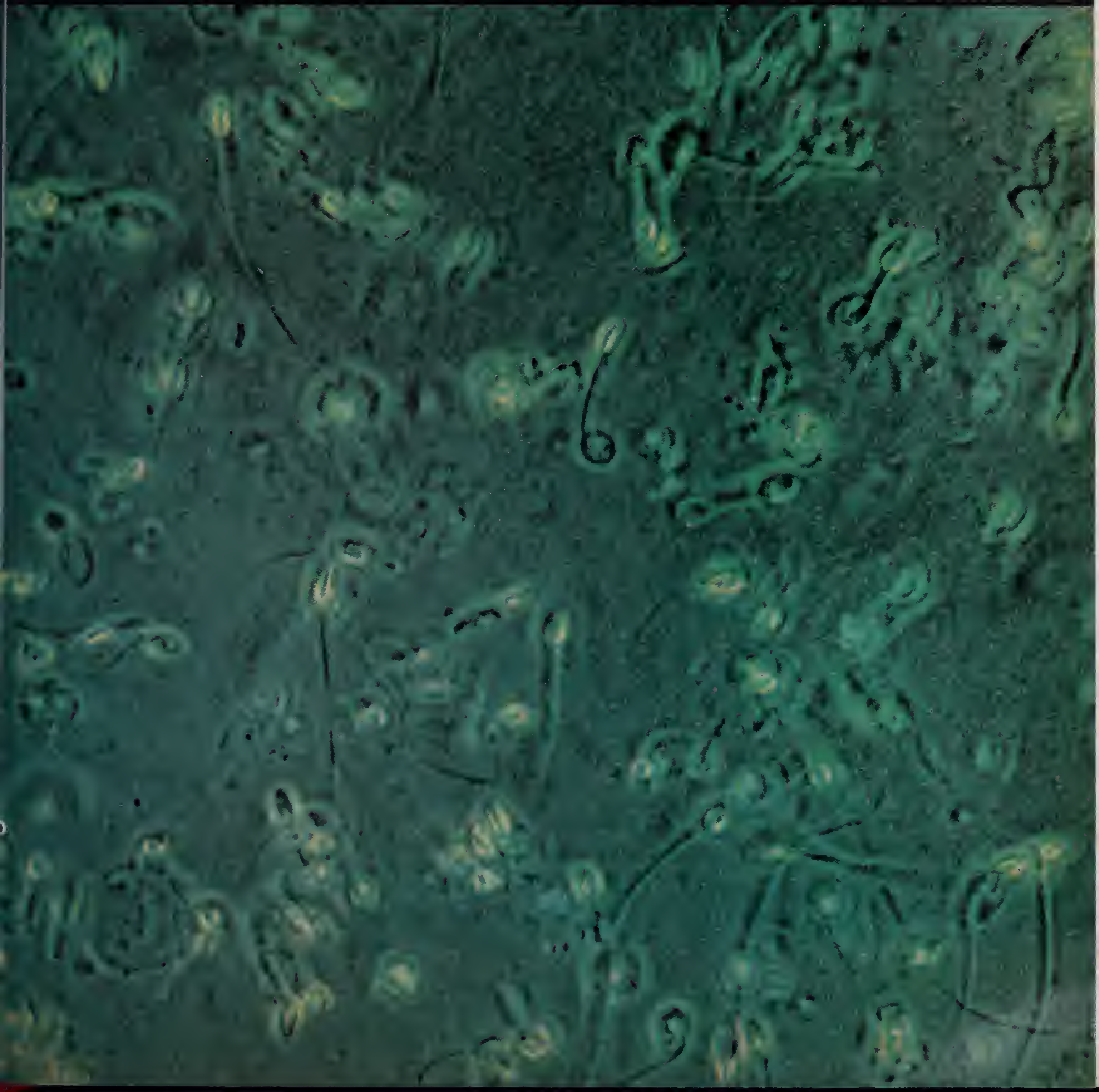
The most recent case on this subject depended upon the nature of the act of a student nurse at an infirmary in performing a hypodermic injection. Was this an act "of professional nature" so as not to be covered by a general liability insurance policy? A patient who had sustained nerve degeneration and loss of control of his right foot as the result of an injection sued the general liability carrier for damages. The policy excluded liability for injuries due to medical or surgical services or treatment, or any service of a professional nature. The patient contended that although the giving of an injection may be an act of a professional nature under some circumstances, it was administrative negligence, as distinguished from professional negligence, for the infirmary (which hired the nurse) to permit the student nurse to give the injection or to administer it in an improper manner. The injection was given in the presence of a surgeon and a supervisor of nurses. The Court of Appeals for the fifth circuit found in favor of the general liability insurance carrier. It is the act itself, said the court, not the title or character of the person performing it, that determines whether it is of a professional nature. This act certainly was of such nature.

Obviously a physician who maintains an office should protect himself by purchasing both professional and public liability insurance.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weigh (increase or decrease), changes in cervical erosion and cervical secretion, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis like syndrome, headache, nervousnes dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonar embolism, neuro-ocular lesions.

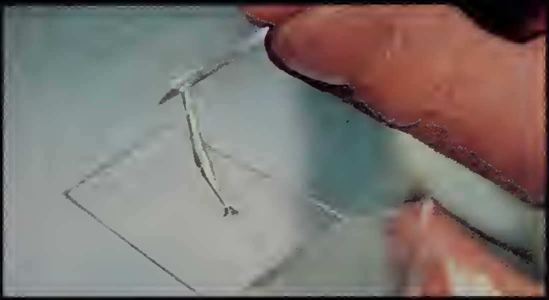
The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

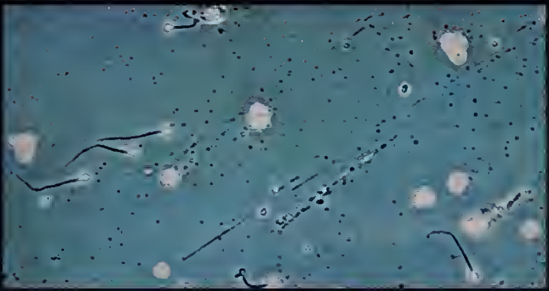
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

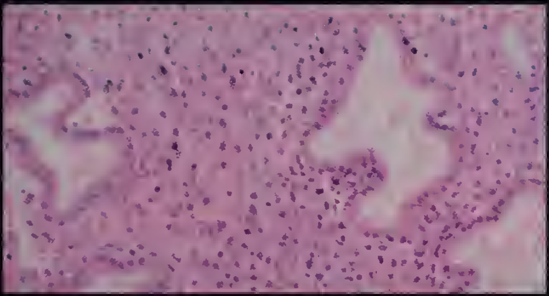
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

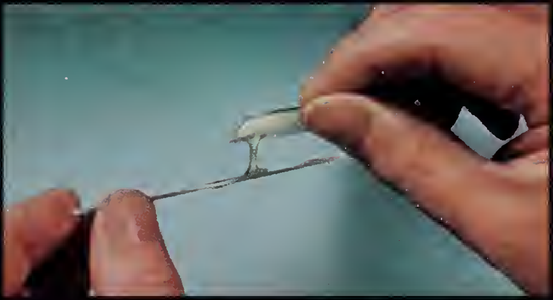


Spermatozoa appear healthy, active, freemoving.

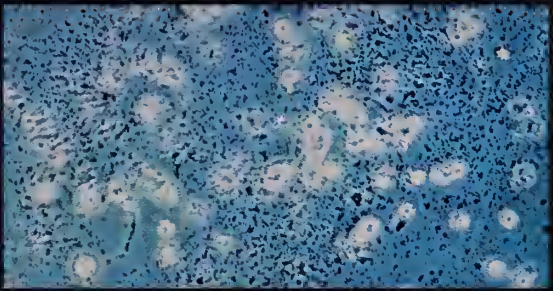


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

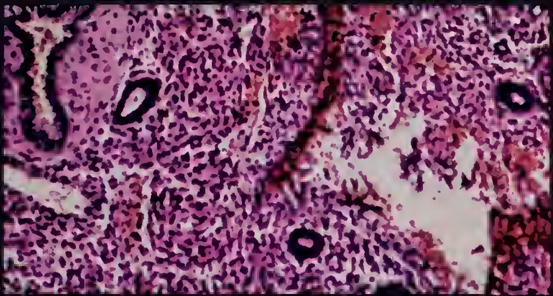
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]

now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

Liability Insurance Premium Rates Rise

The rising cost of malpractice claims across the country is forcing a general increase in premiums in many states for physicians' and surgeons' professional liability insurance, a national insurance ratemaking organization said today.

The National Bureau of Casualty Underwriters —which determines premium rates on professional liability insurance for its affiliated companies—announced that rates are being revised in 30 states and the District of Columbia.

The rate level in Michigan was increased 20 per cent.

The NBCU also announced a new classification which will include anesthesiologists, neurosurgeons, obstetricians-gynecologists, orthopedists, plastic surgeons, and otolaryngologists who perform plastic surgery. These specialists will pay higher rates than would have applied if this change had not taken place.

In the five year period from 1959 through 1963, the NBCU pointed out, Bureau companies sustained large underwriting losses on professional liability coverages for both physicians and surgeons.

On the physician classes, losses and company operating expenses amounted to $140 for each $100 in premiums during 1959-1963. This means that companies sustained an underwriting loss of $40 for each $100 of premiums.

On the surgeon classes, losses and expenses totaled $151 for each $100 in premiums during the same period, resulting in an underwriting loss of $51 for each $100 of premiums.

The NBCU said that, in view of the extremely adverse experience in these lines, these rate revisions must be considered "moderate."

Rouse, at Flint, Discusses Physician Income

AMA President Milford O. Rouse, M.D., speaking to the Genesee County Medical Society, criticized some recent Washington news articles which, using new Bureau of Labor statistics, commented on the rapid rise in doctor's fees.

The Bureau of Labor claimed that physician's fees had risen 8.9 per cent from August, 1966, to August, 1967.

Articles based on the statistics "did not specify whether they were talking about total income or per item fee," Doctor Rouse said. "And there is a difference."

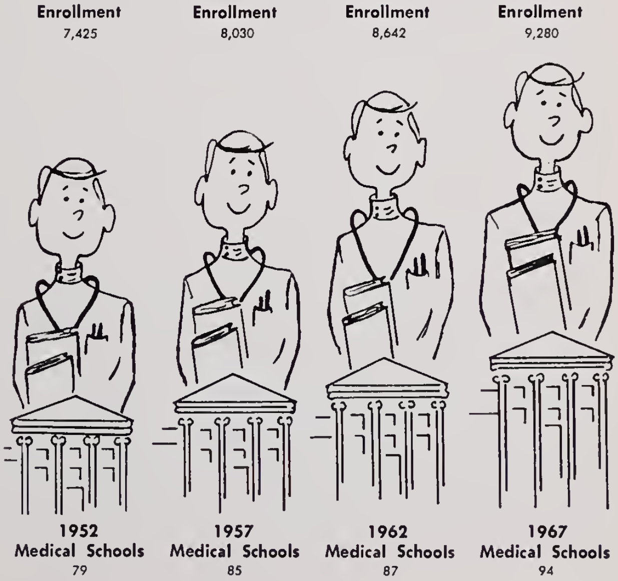
"Certainly," Doctor Rouse said, "the total income of an individual doctor probably has increased moderately, but only in keeping with the constant rise in the cost of living."

Main cause behind the rise in physician income, Doctor Rouse observed, is government health services which have paid the doctor's fee for low-income patients, who the doctor served without charge in the past.

The AMA president called the average physician's annual income of approximately $25,000 a "very modest, equitable comparison with that of the other professions."

Doctor Rouse called upon labor and government to "share with the medical profession the responsibility to hold down to a minimum any rise in medical costs in every way possible."

MED SCHOOL ENROLLMENTS CLIMB



Social Security Official Explains Amendments; Some Become Effective This Month

BY ROGER W. SEAMON, DISTRICT MANAGER
SOCIAL SECURITY ADMINISTRATION
DISTRICT OFFICE, LANSING

Editor's Note: Major changes in the Social Security Law, signed by the President in January, were explained in the February issue. Many physicians have continued to raise questions about some of the new amendments, so another article is offered this month. MSMS members are urged to save this following article, and also to go back and clip out pages 282, 283 and 286 in the February issue of Michigan Medicine.

The changes in the Social Security law signed by President Johnson on January 2, authorized a benefit increase of at least 13% in the social security checks of approximately 24 million social security beneficiaries. Some beneficiaries will receive more than a 13% increase. For example the minimum benefit for workers retiring at age 65 is increased from $44 to $55. The first increased benefit checks will be payable early in March 1968.

RETIREMENT AND SURVIVORS PROVISIONS

These amendments also will enable beneficiaries who continue to work to make more money and still draw some or all of their social security benefits. The amount of money a person can earn in a year and still draw all his social security benefits has been raised. Beginning with 1968 a person who makes as much as $1680 can still collect all of his social security benefits for the year. Even if he earns considerably more than that he may still draw some benefits. Regardless of how high his earnings are for a year, he would still receive a social security benefit for any month in which he did not earn more than $140 in wages and was not active in self-employment.

The new social security amendments also changed the conditions for determining when a child can receive benefits upon the social security account of a working mother. Until now a child was considered dependent upon his mother (and therefore eligible for monthly benefits when she died, retired or became disabled) only if his mother was actually supporting the child or if she had worked under social security for at least 1½ years out of the last 3 years before her death, retirement or disability. The amendments eliminate the support and the recent work requirement.

Beginning with the checks in March 1968, benefits are payable to the child of a woman worker who has died, retired or become entitled to social security disability benefits if his mother has accumulated enough social security credits to be "fully insured," whether or not these credits were for recent work under social security.

DISABILITY PROVISIONS

Another very important change in the law makes it possible for the disabled widow or dependent widower of a deceased worker to receive disability benefits beginning at age 50. Under the old law a widow could not get social security benefits until she reached age 60, unless she had in her care a child who was entitled to payments based on her husband's earnings. Now, a widow whose husband had worked long enough under social security can be eligible for monthly benefits as early as age 50 if she is severely disabled. However, she can be eligible for these disabled widows benefits only if her disability started before or within 7 years after her husband's death, or within 7 years after the period when she received benefits as a widow with minor children.

Another change in the disability provisions changed the amount of work credits which a young disabled person needs in order to qualify for social security disability payments. In the past applicants for disability benefits had to have work credits for at least 5 out of the 10 years before becoming disabled. Now, workers becoming disabled before age 31 need less work credit. The required work varies from 1½ years up to 5 years, depending upon the applicant's age at the time of onset of disability.

FINANCING

The amendments also changed some of the provisions governing the financing of the program. Under the new law the contribution rates remain the same for 1968, 4.4% for employers and employees and 6.4% for self-employed people. Next year the rate will be increased to 4.9% for self-employed people.

Beginning with 1968, earnings up to $7800 a year are subject to social security contributions and will also count toward social security benefits. Therefore the one out of four people who earns over $6600 a year will be paying social security contributions on up to $1200 more of his annual earnings. However, those who pay at this higher rate will receive substantially higher benefits, in addition to getting credit for the 13% increase. For example, a person who is 50 in 1968 and will pay social security contributions on earnings of $7800 a year for only 15 years will collect a retirement benefit of $188.80 per month. This compares with $155 per month which he would have collected under the old law, an increase of 21.8%.

MEDICARE

A substantial number of changes were made in the Medicare program. One of the more important is that now a Medicare beneficiary can make a claim for Part B reimbursement for doctor's services based upon an *itemized* bill. In other words it is no longer necessary that the Medicare beneficiary have paid the doctor bill before claiming Part B Medicare reimbursement. Of course the two alternate claims methods authorized by the original Medicare legislation in 1965 are still in force: the assignment method whereby the doctor submits the claim directly to the Medicare carrier and receives the payment direct from that carrier and the request for payment method by the Medicare beneficiary on the basis of itemized, receipted bills.

The new law also eliminates the requirement that there be a physician's certification to the medical necessity for admission to general hospitals. It also eliminates the outpatient hospital services certification requirement. These changes do not alter the basic concept that Medicare reimbursement will be made for only medically necessary covered items and services. They do, however, recognize the fact that patients are admitted to hospitals only on a physician's order, and the requirement that the hospital obtain written certification of this fact resulted in largely unneccessary paper work. Physician certification is retained for payment of services by psychiatric and tuberculosis hospitals, extended care facilities and home health agencies. The requirement for physician certification after inpatient hospital services have been furnished over a period of time is also retained.

Beginning January 1, 1968 a person covered under the hospital insurance part of Medicare will be eligible for 60 additional days of care partly paid for by Medicare. This is a "lifetime reserve" that can be drawn upon after the beneficiary has used up the 90 days in a "spell of illness." During these additional days, Medicare will pay all but $20 of the covered hospital expenses.

Some of the other changes in the Medicare provisions include.

a. Certain non-routine services of podiatrists or surgical chiropodists are covered under Part B effective January 1, 1968. Diagnosis and treatment of flat feet or partial dislocations are not covered.

b. Purchase of durable medical equipment in certain circumstances.

c. Coverage of outpatient physical therapy services has been expanded to include not only participating hospitals, extended care facilities and home health agencies, but also some clinics, rehabilitation agencies and public health agencies which meet certain conditions.

d. Portable X-ray services performed in a beneficiary's home by a non-physician X-ray operator are now covered by Part B if the operator performs the services under the general direction of a physician, and the tests are performed on a physician's written authorization and they must be read by a physician.

e. All procedures to determine the refractive state of the eyes performed during an eye examination are now *excluded,* even if provided in connection with furnishing prosthetic lenses. The exclusion applies to refractions performed by ophthalmologists, as well as other physicians and even when the total examination is for the treatment or diagnosis of eye disease or injury.

f. There is now a time limit of filing claims for medical insurance reimbursement. Claims for Part B reimbursement related to services provided by doctors in July, August or September 1966 will have to be filed by March 31, 1968. Claims for services in the period from October 1, 1966 through September 30, 1967 must be filed by December 31, 1968.

The premium which Medicare beneficiaries pay for their Part B medical insurance will be raised from the current rate of $3 to $4 per month in April 1968. This increase will be used to finance the extra expenditures due to the expanded benefits provided under the amended program, more frequent use of covered medical services by the aged, and anticipated increases in physicians' fees. More detailed description of these amendments are contained in pamphlets SSI-1967-1 and SSI-1967-2 which can be obtained from your social security office without charge.

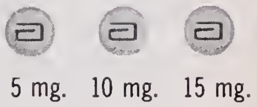
An anorectic will help her lose weight–but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the
secret
of
controlling
your weight

Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444

To
help you
control your
weight...

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT
801444

AMA DOORS OPEN, INVITES VISITORS

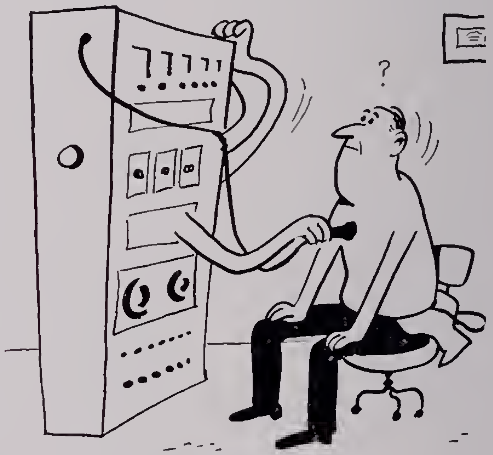
Planning to be in Chicago in the foreseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

During the third quarter of 1967 nearly 500 persons were conducted on tours of the headquarters offices. This unusually heavy schedule, almost equaling tour attendance for the entire preceding year, indicates increasing personal interest in the AMA by individual physicians. Approximately 60 per cent of those taking tours are physicians. The remainder are medical society personnel, members of the Woman's Auxiliary, medical assistants, those employed in allied health professions and students.



WHAT'S THE PUNCH LINE?

Almost everyone has at times thought he could write and/or draw a cartoon. So here's your chance.

Write a caption for this cartoon situation.

Write the gag line that would spark a smile. Send it to Publication Committee, 120 West Saginaw, East Lansing, Michigan 48823; and the best caption—or two—will be printed.

Blue Shield Comments On 1967 and New Year

(Note: Following are some excerpts from the Michigan Blue Shield Report to the MSMS Council, January 24. The Report was described by Blue Shield as "a capsulized annual report, highlighting the operations of Michigan Blue Shield during 1967 and providing some summary corporation projections for 1968.—Brooker L. Masters, M.D., Publication Committee Chairman)

Operations

Subscription Income—Regular: Subscription income from our regular Blue Shield programs was $143,477,000 in 1967 compared to $134,058,000 in 1966, an increase of 7.03 percent. Income is projected to be $149,707,000 in 1968 or 4.31% more than in 1967.

Medicare: Gross Medicare bill receipts for 1967 were 1,233,500. The forecast for 1968 is 1,396,700 or a 13.23 percent increase. Based on 1967 year-end estimates, in the first full year of Medicare we will have paid $35,641,424 to physicians (under Blue Shield's Part B responsibility) for 1,063,082 receipts.

Medicaid: Under Medicaid we paid 1,438,921 claims in 1967, for a total of $15,070,256. It is estimated that this volume of claims will increase 11 percent in 1968 with an inestimable increase in payments to providers of service.

Blue Shield's expansion in regular and government programs, was reflected in the increased number of claims submitted for payment during 1967 and the total pay out to providers and subscribers compared to 1966. Following is a comparison of claims and total pay out, plus estimates for 1968.

Total Claims Payments Government and Regular Programs

Year	Claims	Payments
1966	3,367,727	$120,819,000
1967	6,074,823	175,468,680
1968	7,000,000	200,000,000

Providers: The payments reported above were made to 8,331 doctors of medicine, 1,919 doctors of osteopathy, 258 podiatrists, 620 dentists and 421 ambulance companies. Under Medicaid, we also paid for more than 1,500,000 prescriptions filled by more than 2,000 pharmacists.

Enrollment: Regular Blue Shield programs covered a total of 4,382,500 persons in 1967, an increase of 191,329 over the previous year or an increase of 4.57 percent. We are planning for an approximate 5 percent increase in persons covered under regular programs in 1968. Michigan Blue Shield now serves more than 5,492,000 people in all its programs, over half the population of the state.

Manpower: Our increase in business required additional staff. Accordingly, Blue Shield employment rose to 1,145 in 1967, up from 725 at the end of 1966. We foresee a payroll of approximately 1,350 employees by the end of 1968, or an increase of 18.4 percent.

Operating Expense—Regular: Total operating expense for regular business in 1967, including direct expense and those incurred for services performed by Blue Cross for Blue Shield, was $10,889,000 compared to $9,251,000 for 1966. This represents 7.56 percent of 1967 subscription income, compared to an expenditure of 6.9 percent of 1966 income. This year will probably show a higher increase, but in relationship to other Blue Shield Plans' operating expenses, we expect the ratio below to be maintained.

Operating Expense as a Percentage of Benefits — June 30, 1967

All Blue Shield Plans	9.38%
15 Largest Plans	9.66%
Michigan Blue Shield	7.56%

Automobile Negotiations and Allied Efforts Involving New Programs

Labor-management negotiations in the automobile industry involving health care plans were concluded this fall. Benefits negotiated are in keeping with Blue Shield's new programs of extended benefits and variable fees.

While these programs will be effective November 1 of this year for the motors industry, our planning and other implementation activity must be completed in the next several months in order to insure that the program will be operative not only in Michigan but in other states where motors employees work and receive medical care.

Various parts of the new programs are in effect now in steel, rubber and electrical workers' contracts.

Our first shifts of other regular business from M-75 to the new programs are tentatively scheduled to begin on April 1.

Governmental Program Changes

On January 2, the President signed the 1967 Social Security Act Amendments, which contained many changes in the Medicare program.

Perhaps the most essential change in the new law eliminates need for a receipted bill.

Sees Attitude Changing In Nursing Toward The Male Nurse

BY PETER HOHEISEL
OF THE MSMS STAFF

While most of the sexual revolution publicity today goes to the ladies who are taking over formerly all-male careers, there is a counter-revolution taking place in the field of nursing.

A few years ago, it was practically unheard of for a man to want to be a nurse. Today it is still practically unheard of, but not quite.

The change, however, is not so much in numbers but in attitude. Nationally about 1% of registered nurses are men. In Michigan about 2% of students and registered nurses are men.

The real change is in the attitude within the profession itself. In October, more than 9,000 members of the Michigan Nurses Association elected a man, John Wick, BA, MA, RN, to a two-year presidential office.

"Men are very well accepted today in the nursing field," said Mr. Wick, who is also director of Nursing Service at Botsford General Hospital and Ziegler Osteopathic Hospital. "Nursing is an excellent career for a man if he is willing to get graduate training."

A career in nursing generally does not attract young men right from high school. "Very often we get mature men who are around 30," noted Ann Conley, BA, MA, RN, head of undergraduate nursing at Wayne State University. "We get many men out of service who have had satisfying experiences as corpsmen and want to make this their life's work. Some of our students also come from work at mental hospitals as psychiatric aides or attendants."

"There are so many places where men are badly needed," continued Miss Conley. "For example, in some orthopedic services where children are hospitalized — this situation can easily become a woman's world, but children need men too. Some of the other places where men are very much needed are industrial medicine and psychiatric services for children and adolescents."

Where can men go for nurses training? All the state universities and community colleges which have nursing programs are open to men, and many of the hospital programs are open to them. Some of the hospitals do not accept men candidates. For example, Henry Ford, Harper and Deaconness Hospitals in Detroit do not accept men, while Grace, Mercy and Providence do. Also some of the smaller girls colleges around the state would not accept men into their nursing programs.

Is there any difference in the training of male and female nurses? Not substantially or in theory because both have to pass the same state boards. As far as clinical training goes, according to Ann Lardie, RN, Recruitment Coordinator of Nursing Careers for the Michigan League for Nursing, there may be some adjustment. For example, though the men would be trained in theory, they would not actually be involved in post-partum care for mothers in some programs.

HARPER HOSPITAL

Shown above is one of the two ambulance wagons which Harper Hospital operated in Detroit in the 1880's. The history of the ambulance service is part of the larger hospital story which has now been told by Frank B. Woodford and Phillip P. Mason in a book called **Harper of Detroit**. Published by Wayne State University Press, the book sells for $7.95 and is available at the Handy Shop in Harper Hospital.

MSMS COMMITTEES ARE HARD AT WORK:

Friday, January 5
Michigan Chapter, American Society of Landscape Architects
MSMS Headquarters

Monday, January 8
Ingham County Medical Explorers
MSMS Headquarters

Tuesday, January 9
COMMITTEE ON LEGAL AFFAIRS
MSMS Headquarters
Chairman: Otto K. Engelke, MD, Ann Arbor

Wednesday, January 10
Ingham County Blue Shield
MSMS Headquarters

Michigan Council on Smoking and Health
MSMS Headquarters

JUDICIAL COMMISSION
MSMS Headquarters
Chairman: Donald N. Sweeny, Jr., MD, Detroit

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE
Canopy Restaurant, Brighton
Chairman: Herbert A. Raskin, MD, Detroit

Thursday, January 11
Ingham County Woman's Auxiliary
MSMS Headquarters

Michigan Partners of the Alliance
MSMS Headquarters

LIAISON COMMITTEE WITH STATE BOARD OF REGSTRATION IN MEDICINE
MSMS Headquarters
Chairman: Kenneth H. Johnson, MD, Lansing

COMMITTEE ON REHABILITATION
MSMS Headquarters
Chairman: Richard W. Pomeroy, MD, Lansing

Thursday, January 18
SUBCOMMITTEE ON LAY EDUCATION (of Maternal Health Committee)
MSMS Headquarters
Chairman: Richard T. Mellis, MD, Kalamazoo

COMMITTEE ON RURAL MEDICAL SERVICE
MSMS Headquarters
Chairman: Robert E. Rice, MD, Greenville

Friday, January 19
Michigan School Health Association
MSMS Headquarters

Tuesday, January 23
COMMITTEE ON MEDICINE AND OSTEOPATHY
MSMS Headquarters
Chairman: John J. Coury, MD, Port Huron

Wednesday, January 24
THE COUNCIL
MSMS Headquarters
Chairman: Robert J. Mason, MD, Birmingham

COUNTY SOCIETIES COMMITTEE
MSMS Headquarters
Chairman: John J. Coury, MD, Port Huron

FINANCE COMMITTEE
MSMS Headquarters
Chairman: Robert K. Whiteley, MD, Detroit

PUBLICATION COMMITTEE
MSMS Headquarters
Chairman: Brooker L. Masters, MD, Fremont

AD HOC COMMITTEE TO STUDY BLUE SHIELD
MSMS Headquarters
Chairman: Kenneth H. Johnson, MD, Lansing

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Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

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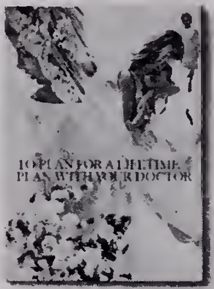

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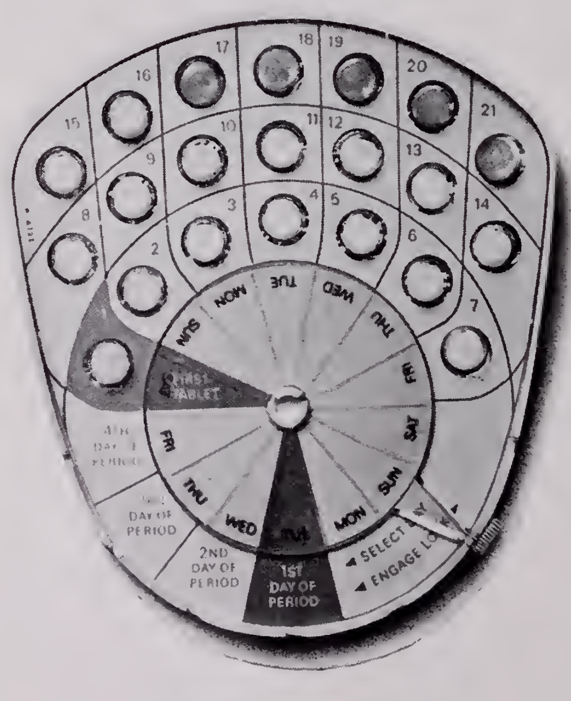

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IN MEMORIAM

C. E. Boone, M.D., Zeeland

Cornelius E. Boone, M.D., long-time Zeeland physician, died December 31 at the age of 81.

He attended Hope College and the University of Illinois College of Physicians and Surgeons where he received his M.D. degree in 1911. After three years of practice at Olive Center, he served as an Army surgeon in World War I. From 1919 until recent months, he practiced in Zeeland. He had served as chief of Staff of the Zeeland Community Hospital and was also affiliated with the Holland City Hospital, Holland. For 15 years he was an examiner for the Selective Service.

Doctor Boone was a Life Member of MSMS and belonged to the American Legion and the Masonic Lodge.

J. W. Lawson, M.D., Detroit

John W. Lawson, M.D., retired Detroit otolaryngologist, died November 15. He was 74.

Doctor Lawson, who was born in Grand Ledge, Michigan in 1893, served in the military during World War I before entering the University of Michigan Medical School.

He received his M.D. degree in 1928, and did his internship at Harper Hospital, Detroit, 1928-29. After postgraduate training in otolarynology, he began the practice of his specialty in 1930. He was a Diplomate of the American Board of Otolaryngology.

G. R. Pray, M.D., Jackson

George R. Pray, M.D., Jackson general practitioner and a past president of the Jackson County Medical Society, died December 24 at the age of 89.

Graduated from the University of Michigan Medical School in 1900, he interned at University Hospital and did postgraduate work at Chicago Policlinic and Postgraduate. He served as prison physician at Jackson from 1902 until 1913 when he opened his own practice.

A member of Phi Beta Pi, he held various offices in the national organization, including Supreme Secretary, Eastern Praetor, Treasurer, and Supreme Archon (President). He was a 32nd degree Mason.

For nine years he served as a member of Foote Memorial Hospital board of control and was examining physician for the military services for many years.

Doctor Pray was a Life Member of MSMS.

I. L. Sparling, M.D., Northville

Irene L. (Martin) Sparling, M.D., retired Northville general practitioner, died December 27 at the age of 72. Doctor Sparling had practiced in Northville for 40 years. She began practice there in 1925, after her graduation from the University of Michigan Medical School in 1924.

Born in Homer, she did her pre-medical studies at Eastern Michigan College. She was affiliated with Beyers Hospital in Ypsilanti.

She was a member of the Business and Professional Women's Club, Garden Club, Presbyterian Women's Organization, and Senior Citizens.

Doctor Sparling was a Life Member of MSMS and a member of Alpha Epsilon Iota medical fraternity.

E. S. Thornton, M.D., Muskegon

Eugene S. Thornton, M.D., Muskegon surgeon and former member of the MSMS Legislative Committee, died December 28. He was 81.

A member of the State Board of Registration in Medicine for 12 years, he had also served on the State Advisory Board of Health and the State Hospital Commission.

He was a gradute of Wabash College and the University of Michigan Medical School in 1916. Except for the period of World War I when he served as a Captain in the Medical Corps, Doctor Thornton practiced in Muskegon from 1916 until his retirement. He had served as chief of surgery, chief of gynecology, and as chief of staff for many years at Mercy Hospital and was a consultant in surgery to Hackley Hospital.

Once president of the Muskegon County Medical Society, he was secretary of the group for eight years. He was a member of the Muskegon County Emergency Welfare Commission, a member of the North Muskegon Board of Education for nine years, and had been chairman of the county Democratic Central Committee. He was a past president of the Muskegon Kiwanis Club and a 32nd degree Mason.

Doctor Thornton was a Life Member of MSMS and a Fellow of the American College of Surgeons and the International College of Surgeons.

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Immediate Action Needed to Stop Unwise Amendment to Chiropractic

MSMS members and all Michigan residents interested in quality health care should contact their State Representatives immediately, and ask them to oppose a single important sentence now being proposed as an addition to the Michigan law licensing chiropractors.

Senate Bill 227 has been placed before the House of Representatives for a vote, and it is proposed to change Section 6 of that law so as to make chiropractors themselves the judge of which analytical (diagnostic) instruments they may legally use in the examination of human beings.

The House of Representatives State Affairs Committee released this bill on March 12 recommending passage of this change in Section 6 and nine other amendments. MSMS had indicated over a month previously, in writing, that it didn't oppose all of SB 227, only the Section 6 change. In fact, MSMS had offered several amendments for consideration, none of which were incorporated.

MSMS has long taken its stand against the objectionable Section 6 amendment. Past President C. Allen Payne, M.D., in his "President's Message" in the June 1967 issue of *Michigan Medicine,* declared: "SB 227 is dangerous because it could give chiropractors the right to use analytical instruments in the examination of patients—with only the chiropractors deciding what instruments they can use." Doctor Payne characterized this as unwise, unnecessary and not in the public interest.

The special issue of *MSMS Medigram* sent March 13 to all MSMS members explained that MSMS had sent a letter January 25 to all members of the House State Affairs Committee indicating that the Amendment to Section Six was "basically the only one" of the proposed 10 amendments that was "absolutely objectionable."

The special *Medigram* explained, in part, that "The law prevents a chiropractor from practicing surgery—but consider all the possible 'analytical' or diagnostic instruments potentially available to chiropractors—legally available so long as they are 'generally used.' The list is endless, and could include instrumentation which, even assuming the chiropractor was capable of using it correctly, diagnoses conditions which they are neither capable of treating or legally allowed to treat."

The only representatives voting against SB 227 were Rep. Kok of Grand Rapids, Rep. Tisdale of Midland, and Rep. Kramer of Royal Oak. Rep. Davis of St. Ignace and Rep. White of Detroit were absent. Voting in favor of the bill were Rep. Sharpe of Howell, Rep. Strang of Sturgis, Rep. Stevens of Detroit, Rep. Marshall of Allen, Rep. Petitpren of Westland, Rep. Jacobetti of Negaunee, Rep. Del Rio and Rep. Hunsinger, both of Detroit.

The bill has already passed the Senate.

STILL TIME, NOW, TO REGISTER FOR MATERNAL MEET

Flint—The Seventh Annual Maternal and Perinatal Welfare Conference, March 26 and 27, is set to go, says Jack W. Thompson, M.D., general chairman.

COMING: Experts from Michigan and around the nation—

ATTENDING: Physicians, professionals, lay people, newsmen.

FINAL WORD: Chairman Thompson urges interested doctors to fill in the reservation form mailed to every member; and to come!

ALL MEMBERS, OTHERS INVITED TO MATERNAL WELFARE CONFERENCE MARCH 26-27; AND CONFERENCE MAY 8 FOR HIGH SCHOOL COACHES, TRAINERS, TEAM DOCTORS

Health Planning Conference Applauded

"The First Annual Conference for Michigan Health Planning, which drew about 350, was well received and applauded by those who participated."

So declared Robert J. Mason, M.D., Chairman, in his comments to The MSMS Council March 6, about the new three-day Detroit conference, February 22-23-24.

The timely conference dealt February 22 with "The Doctors, The Law and The Courts," and with "Health Planning as It Affects the Physician, Hospital and Community" on February 23. February 24 was the annual Conference for Component Society Leaders and featured an Awards Luncheon and an afternoon Quackery Education Conference.

Photographs from the conference will appear in the next several issues of *Michigan Medicine,* along with some of the speeches in full and digests of the other addresses.

MSMS
HEALTH PLANNING
CONFERENCE

Medical legislation in Washington was outlined by C. Darrell Coover, of the AMA Washington office, at the recent Component Societies Leadership Conference in Detroit at the Wayne County Medical Society headquarters. Others on the MSMS-sponsored conference program included Otto K. Engelke, M.D., who reviewed medical legislation under consideration in Lansing, MSMS Council Chairman Robert J. Mason, M.D., shown at right, and MDPAC State Chairman Vernon Bass, M.D.

MICHIGAN
HEALTH
PLANNING
CONFERE

James S. Feurig, M.D.

HEALTH
PLANNING
ONFER

Gerald A. O'Connor, M.D.

Two MSMS members received MSMS Distinguished Service Awards at the recent Michigan Health Planning Conference. At left, James S. Feurig, M.D., MSU Team Physician, received his Award from Bradley M. Harris, M.D., MSMS President. Doctor Feurig is chairman of the MSMS Committee on the Medical Aspects of High School Athletics. At right, Gerald A. O'Connor, M.D., of Ann Arbor, received his Award. Both men were cited for "exemplary leadership in solving medical problems related to organized athletics in Michigan and the nation." Doctor O'Connor, team physician for the University of Michigan, was chairman of the 1967 MSMS Conference on the Medical Aspects of High School Sports held in Ann Arbor.

Coaches, Trainers, Team Doctors to Confer May 8

Robert Murphy, M.D., internist and team physician at Ohio State, will be one of the major speakers at the 1968 MSMS Conference on Medical Aspects of High School Sports, May 8 in Detroit.

The conference, held at the University of Michigan for the past two years, will be in the handsome Rackham Building at 60 Farnsworth, Detroit (across from the Detroit Art Institute and handy to the new underground parking lots). The University Center for Adult Education (WSU-UM-EMU) will cosponsor the program for high school coaches and trainers and team physicians.

Over 300 attended the 1967 conference. The popular annual event is presented by the MSMS Committee on the Medical Aspects of Organized Athletics with James S. Feurig, M.D., MSU team doctor, as chairman.

A complete program and reservation blank will be sent to every MSMS member and to coaches.

ADD: IN MEMORIAM

In addition to the names reported in the March "In Memoriam" the following news has reached the MSMS office. Details will follow in the April *Michigan Medicine*:

Irmel W. Brown, M.D., Kalamazoo, died February 17.

Harry E. Carnes, M.D., Detroit, died January 28.

Crosby D. Eaton, M.D., Detroit, died January 27.

Dwight Goodrich, M.D., Traverse City, died January 14.

William Klein, M.D., Detroit, died December 9, 1967.

Charles T. Lewis, M.D., Detroit, died January 2.

Charles K. Stulik, M D., Union Pier, died February 1.

WSU Alcoholism Symposium April 11-12

Twenty-five presentations, including speeches by Donald Jones, M.D., on "Effect of Ethanol on Blood Lipids," and Richard Bing, M.D., on "Cardiac Metabolism in Alcoholic Patients," both from Wayne State University's Medical School, will be given at a symposium on "Biochemical and Clinical Aspects of Alcohol Metabolism," sponsored by the WSU School of Medicine, at the Wayne County Medical Society headquarters in Detroit, April 11 and 12.

Wives Attend New Workshop On Legislation

"We had a wide representation from surrounding counties and everyone I talked to seemed very enthusiastic about the day," said Mrs. William Gamble, president of the state Woman's Auxiliary, in commenting on the "Legislation Day," held at MSMS headquarters March 12 for the county auxiliary presidents, presidents-elect, legislative chairmen, and state board members.

In the morning the ladies met in three discussion groups to discuss MSMS Legal Affairs Committee decisions on various bills pending in the legislature. Glenn E. Moore, M.D., of Flint, Francis P. McQuillan, of Jackson, and M. A. Riley, MSMS legislative counsel, rotated between the groups to present the position of MSMS Legal Affairs Committee.

The afternoon was devoted to visiting senators and representatives in the capitol and watching the legislature in action. "Many of the women hadn't met their state representative or senator," Mrs. Gamble said. "Visiting the MSMS headquarters and the capitol was also valuable and interesting."

MAP Congress Set May 10-12 at Boyne Highlands

Plans are developing for the 9th Annual Congress of the Professions to be held at Boyne Highlands, Harbor Springs, May 10-12. Theme of the Congress, sponsored by the Michigan Association of the Professions, will be "Practical Aspects of the Professional Concept." Gilbert B. Saltonstall, M.D., a past president of MSMS, is currently serving as president of the Michigan Association of the Professions.

A board meeting will be held on Friday afternoon, May 10, followed by a President's Reception in the evening.

Saturday morning meetings will begin at 8 with an American Association of the Professions breakfast, followed by the MAP annual business meeting at 10. The noon luncheon will be open to all professionals and their wives.

In the afternoon there will be a general assembly, during which "The Defense, Promotion, and Value of the Professional Concept" will be discussed. Reception and dinner will be held in the evening.

Families of professional persons will be invited to a brunch on Sunday morning at 10.

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WSU Alumni Event to Focus On Sexuality

The clinical section of Wayne State University Medical Alumni Association's annual meeting May 15, at the Sheraton-Cadillac Hotel in Detroit, will focus on "Human Sexuality and Modern Marriage."

Alumni President Mario Petrini, M.D., says, "The program should be helpful to the private practice physician because more and more people are bringing their sexual problems to him and the physician is often poorly prepared to counsel people."

Two of the major speakers are from the Bowman Gray School of Medicine. Clark Vincent, Ph.D., director of the behavioral sciences center and professor of sociology, will discuss "Human Sexuality: A General View." Robert Coombs, Ph.D., assistant professor of sociology, will speak on "Acquired Sex Attitudes and Information – Role of Home and Parents."

"Changing Sexual Expectations in Women – the Special Role of the Physician's Wife," will be the topic of Peter Martin, M.D., clinical professor of psychiatry at the WSU Medical School.

Harold Lief, M.D., professor of psychiatry and director of the division of family study, University of Pennsylvania, will speak on "Psychodynamics of Teaching Medical Students Sex Education."

The banquet will honor the class of 1918 and will observe the 100th anniversary of the WSU Medical School.

MSMS Offers PG Speakers

Twenty programs will be presented this spring in Michigan by the MSMS Committee on Postgraduate Medical Education, in cooperation with the three Michigan medical schools and the state Department of Public Health.

A printed program listing all the speakers and their subjects is being prepared now to be mailed to all MSMS members in the counties to be served by the 20 programs. The host component medical society indicated its preferences on speaker and subject and the MSMS Committee Chairman Harry A. Towsley, M.D., worked with the cooperating groups to arrange the travel schedules, etc.

Following is a list of the communities which will host the programs, many of which will include a clinical demonstration and discussion:

ALPENA — THURSDAY, APRIL 18
BATTLE CREEK — TUESDAY, MAY 7
CADILLAC — THURSDAY, MAY 23
GRAYLING — THURSDAY, APRIL 25
LANSING — DATE TO BE SET
HOWELL — TUESDAY, MAY 7
MIDLAND — THURSDAY, MAY 9
MUSKEGON — WEDNESDAY, MAY 15
NILES — TUESDAY, MAY 21
HOLLAND — FRIDAY, MAY 3
PETOSKEY — THURSDAY, APRIL 11

The Upper Peninsula calendar will list the following:

HOUGHTON — MONDAY, MAY 13
SAULT STE. MARIE — MONDAY, MAY 13
IRONWOOD — TUESDAY, MAY 14
MANISTIQUE — TUESDAY, MAY 14
ESCANABA — TUESDAY, MAY 14
IRON MOUNTAIN — WEDNESDAY, MAY 15
MENOMINEE — WEDNESDAY, MAY 15
MARQUETTE — THURSDAY, MAY 16

WCMS To Ballot Soon; Installation, May 6

Installation of James C. Danforth, Jr., M.D., as new president of Wayne County Medical Society, and announcement of election results, will take place on Monday, May 6, at the Wayne County Medical Society Headquarters in Detroit.

On April 19, ballots will go out to elect trustees, secretary, delegates, council, section chairmen, and geographical representatives.

Beaumont Lecture To Offer Delgado

"The mind today is not considered a philosophical entity but a physical reality which can be investigated by experimental means," says José M. Delgado, M.D., in discussing the significance of his forthcoming Beaumont Lecture, April 1, at the Wayne County Medical Society headquarters in Detroit. Doctor Delgado, professor of Physiology at the Yale University School of Medicine, will speak on "Reaching for the Mind in the Depth of the Brain." Preceded by dinner at 6:30 PM, the Beaumont lecture will begin at 8:30.

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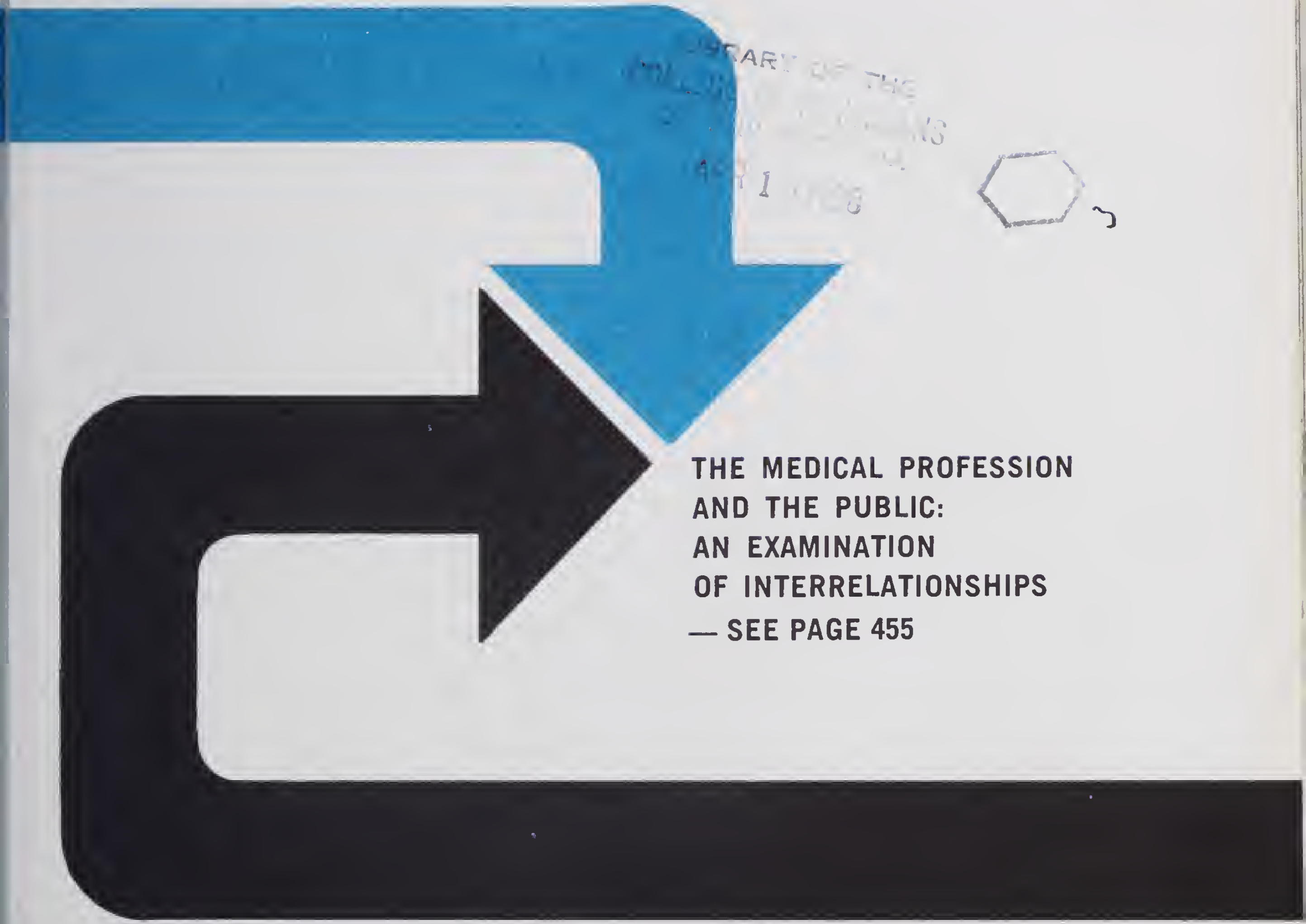

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THE MEDICAL PROFESSION AND THE PUBLIC: AN EXAMINATION OF INTERRELATIONSHIPS

— SEE PAGE 455

MICHIGAN STATE MEDICAL
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VOLUME 67, NUMBER 7
APRIL 1968

AMONG THE IMPORTANT ARTICLES:

Clinical Report on Teflurane
Goiter, Persistent Medical Enigma
Blue Shield President Asks:
How Common Is Our Cause?
MSMS Presents Many Awards

SEE THE PROCEEDINGS OF SPECIAL MEETING

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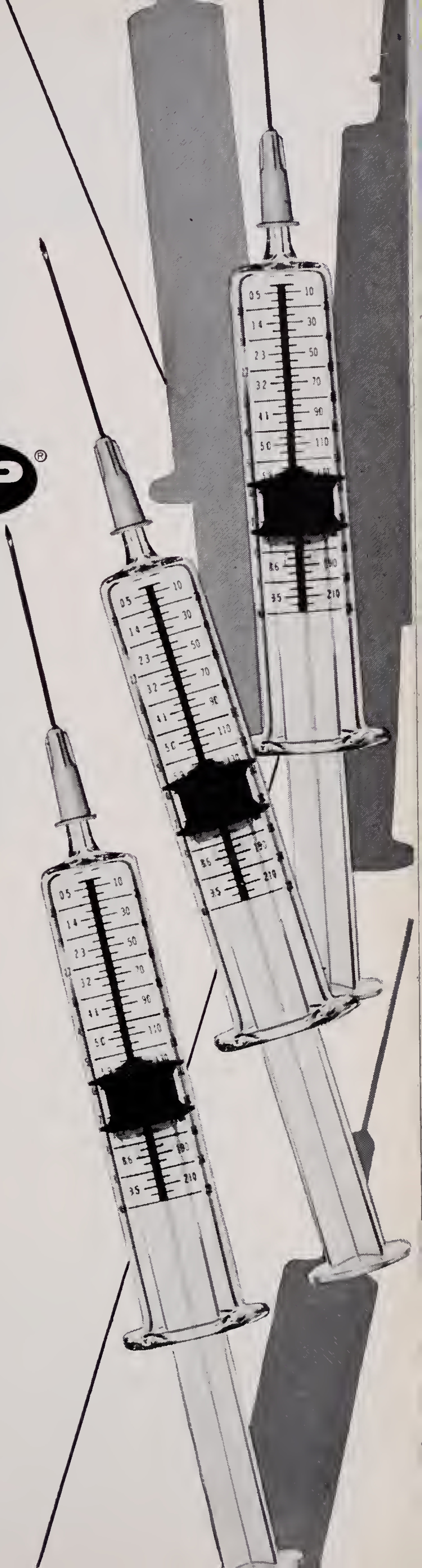

MICHIGAN MEDICINE

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MSMS members may wish to pull out the four cream-colored pages immediately after the blue breaking-news pages in the middle of this issue. Members may want to read and file the official actions of the recent special meeting of the MSMS House of Delegates.

Pages may be removed easily now from the perfect-binding method used by MICHIGAN MEDICINE.

ABOUT THE COVER

The cover this month calls attention to the guest article on page 455, which was commissioned by the MSMS Committee on Socio-Economics. Two previous articles in the series appeared in 1967. The appropriate design, about "The Medical Profession and the Public: An Examination of Interrelationships," was developed by Dar Davis, graduate art student and art instructor at Michigan State University.

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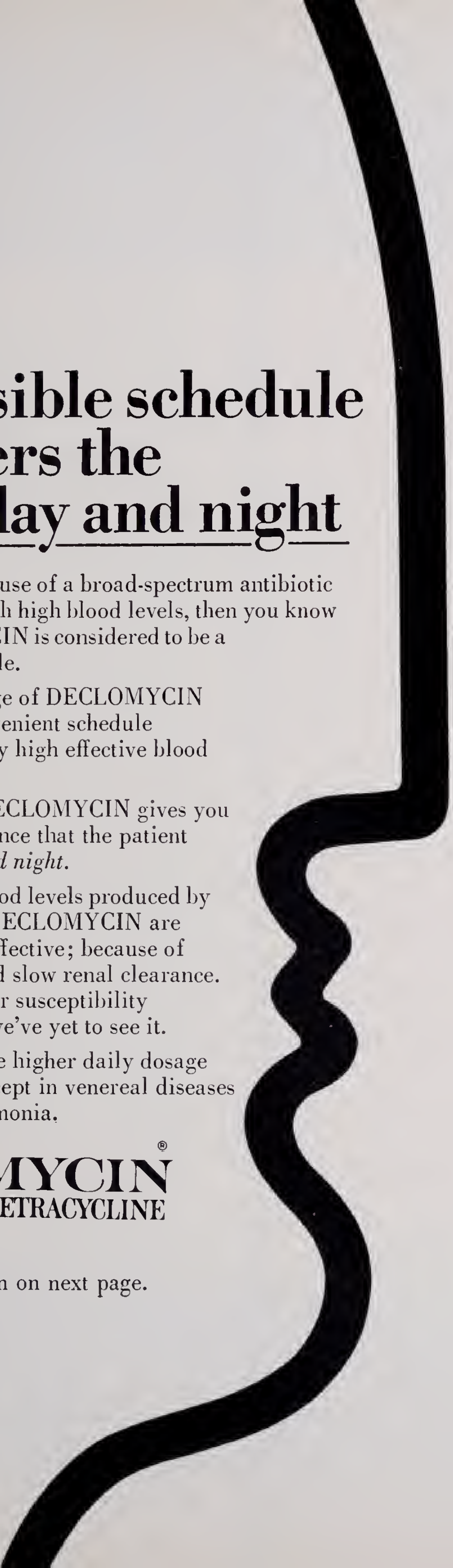

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Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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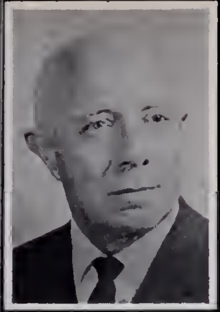


BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Why? Why? Why?
When? When? When?
How? How? How?

Why do governing boards try to operate hospitals without a single board member who is qualified to practice medicine?

Why did the 1962 or 1963 MSMS House of Delegates resolution calling for at least one doctor on every hospital board have virtually no impact?

Why? Why? Why?

* * *

When did the pattern of hospital operation develop with physicians deliberately excluded from the hospital boards of directors?

When did your local hospital board decide not to honor the MSMS resolution of 1962 or the one of 1963?

When? When? When?

* * *

And now, we wonder how will the hospital board members and administration — and the local communities — react to the new recommendation of the reputed National Advisory Commission on Health Manpower? That impartial advisory group, appointed by the President, declares: "Medical and hospital associations should jointly explore means to increase the physician's responsibility for the successful and economical arrangement of hospital operations." Specifically, the recommendation suggests the consideration "of including physicians in the membership of hospital boards of control." The AMA Executive Committee, in commenting on the NACHM recommendation, points out that "this has long been urged by the AMA and would go far toward better management of hospitals."

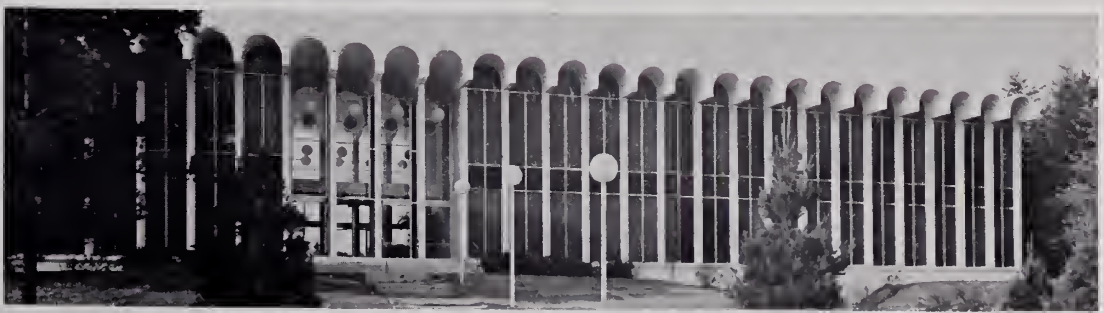
How can local hospitals ignore both the MSMS resolutions and the recent AMA resolution on the same subject?

How can MSMS members call attention to this void in good hospital planning and operation to their community leaders?

How? How? How?

* * *

As president of MSMS, I challenge and urge every MSMS member to let all thinking, reasonable people know that a hospital governing board with no doctor of medicine as a member is just not soundly constituted. ☐



MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Goiter, A Persistent Medical Enigma

BY GEORGE H. LOWREY, M.D.
SCIENTIFIC EDITOR

Just over 50 years ago, Marine and Kimball reported that they were able to prevent goiter in a large number of children if their diet was supplemented with small quantities of iodine.

Subsequent studies confirmed the value of these observations and it was thought that the goiter problem had been solved with the exception of a small percentage due to hyperthyroidism or Graves disease and various types of neoplasia. So-called lymphocytic thyroiditis had been described but at least in this country, it was considered of minor importance. The incidence of thyroid enlargement unassociated with other evidence of thyroid malfunction decreased remarkably over the next few decades.

The once familiar sight of the patient with a huge tumor the size of a baseball under his chin became a distinct rarity.

HOWEVER, THE PROBLEM obviously was not completely solved. It soon became apparent that iodine was a double-edged sword. As a supplement to the diet it certainly was beneficial in the prevention of so-called endemic goiter. When given in slightly larger quantities such as that found in many cough syrups or medications for the therapy of the asthmatic, and especially if these were taken over a prolonged period of time at fairly frequent intervals, marked enlargements of the thyroid could occur.

Even though the use of iodized salt became almost, but never completely, universal, surveys as recently completed as the late 1950's and early 1960's show an incidence of goiter of from 3% to more than 10%.

IN THE TECUMSEH study, the incidence was 2.9% in males and 10.2% in females. Nearly 40% of the families studied did not use iodized salt so the question could be asked, 'Why was the incidence of goiter so small?' Similar studies revealed like findings in many parts of the world.

Biopsy studies in areas as diverse as Boston, Glasgow, and Goteborg revealed that more than 30% of goiters in all ages were the result of chronic lymphocytic thyroiditis. This condition is generally considered to be benign although occasionally it does progress to thyroid deficiency.

Statistically it was shown that many of these patients had an elevated circulating thyroid antibody level and some a transient elevation of protein bound iodine. Unlike many other goiters, response to therapy with thyroid was not very spectacular. Decrease in size of the gland was seldom dramatic and often no change resulted. Some authors now consider chronic lymphocytic thyroiditis to be the single, most common cause of enlargement of the gland in children and young adults in this country.

GOITER CONTINUES to be a problem throughout the world. Its geographical distribution is widespread and does not spare the affluent areas in deference to the less advantaged. Iodine deficiency still remains a problem in some areas but chronic thyroiditis, the exact etiology of which remains unknown, would appear to be the explanation for many. In addition, chronic medication with goitrogenic agents must be taken into account as well as the more uncommon heritable disorders of hormone synthesis.

Finally, neoplasms of the thyroid must always enter the differential diagnosis and the fact that they are found more frequently in regions of endemic goiter is a further disturbing thought.

Best Wishes! Component Society Leaders

BY ROBERT J. MASON, M.D.
CHAIRMAN, THE MSMS COUNCIL

New officers are now in harness for the 55 component medical societies and the nominating committees already are watching for the potential 1969 leaders.

May I quickly wish the new officers every success possible. May I also invite them to call upon their MSMS district councilors and MSMS staff members for assistance and advice.

The rank-and-file members are grateful to the physicians who do accept leadership responsi-

Continued on Page 441

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16 White—Ethinyl Estradiol, 0.1 mg. Tablets, 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

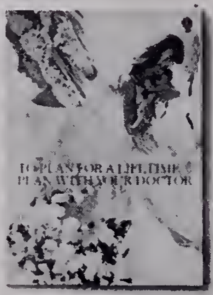
continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

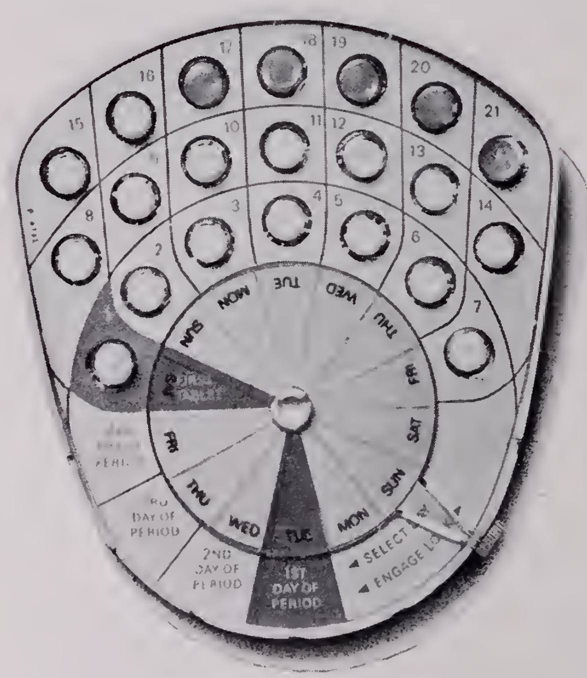
Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control



A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



in the Pakette® dispenser

ORACON®

16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

MeadJohnson
LABORATORIES

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CONTINUED: VIEWPOINTS

bilities to make the component societies effective. And the loyalty of associates can be a major factor in the success of leaders.

Each of the leaders across the state among the component groups is indeed different. Each has individual traits, each is in a unique situation, and each is working with a component society that has different group characteristics.

ONCE CHOSEN FOR A leadership role, the officer or chairman makes the necessary preparations, and makes the sacrifices necessary to function throughout the year.

The MSMS Council will provide information to help the county leaders. And many MSMS officers, chairmen and staff members will help provide enthusiasm and inspiration.

Earned leadership is leadership at its best, and in general that is what we see in medical organizations. Leadership is not achieved in the "bargain basement." It is learned and earned over the years — and the skills and mental attitudes must be improved each day through constant effort to improve and grow.

MSMS AND THE AMA depend upon the component medical society leaders — and so do individuals in the local community, county, state, nation and world.

Yes, the demands and responsibilities are heavy — but democratic leadership can accomplish much and inspire many.

Best wishes! □

For Public Service

"These 10 Michigan physicians are typical of many who are presidents of local boards of education, civic service clubs, voluntary associations, etc."

That declaration was made by MSMS President B. M. Harris, M.D., when MSMS recently announced that it had established a new award for Michigan physicians who serve as presidents of state-wide, non-medical organizations.

The first 10 awards were made at the recent MSMS Annual Awards Luncheon in Detroit at part of the First Annual Conference on Michigan Health Planning.

The new award will be known as the "MSMS Flag Award," and recognizes the men "in recognition of his meritorius public service as president of . . ." The award, Doctor Harris explained, cites Michigan doctors of medicine "for leadership provided to state-wide groups in such areas as education, welfare, youth, science, health and others."

The new MSMS award both recognizes contributions by many and also challenges all physicians to contribute leadership to important state, national and local groups. MSMS encourages local county medical societies to provide recognition to their members who assume leadership roles in many community organizations.

(The names of the 10 physicians appear in a news article on pages 503 and 504.) □

M.D. Plays Major Role In Home Health Services

GUEST EDITORIAL

BY JOHN A. COWAN, M.D., CHIEF

STATE DIVISION OF ADULT HEALTH

For the development of home health services, the physicians' role of professional leadership is as important to the patient as it is in the hospital, nursing home, extended care facility, clinic, or office. The physician is the key to the success of the plan of treatment for the patient.

Ideally, the initial decision to recommend a patient for home health services should be made by the physician. Related factors to be considered are a feasible home environment for the care of the patient, a willingness on the part of the family to take part in the care of the patient, and of the patient to be cared for at home.

The physicians' role is a multifaceted one. As head of the medical care team, he has the responsibility for the patient's diagnosis, treatment and rehabilitation, if necessary, and must request such services as he feels are needed. In addition to providing medical services to the patient, the physician directs and advises the members of the medical care team: the nurse, physical, occupational, or speech therapists; the home health aide, or representatives of other agencies providing services necessary in the patient's treatment.

HOME HEALTH SERVICES that are successfully coordinated provide continuity in total patient care. Care provided to the patient in the home usually speeds recovery. Self-confidence and independence seem to run higher when an ill patient is in familiar home surroundings and with family and friends. The desirability of home care

Continued on Page 444

An anorectic will help her lose weight–but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg.
10 mg.
15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the secret of controlling your weight

Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444

To help you control your weight . .

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

was lauded by the 1965 MSMS House of Delegates when it adopted Resolution 40.

Patients with arthritis, multiple sclerosis, arteriosclerosis, strokes, polio, muscular dystrophy, and diabetes are among those who may benefit from home health services. These conditions and diseases affect the aged, an ever-growing population, whose health needs already are a challenge. However, age alone is not the determinant of who can benefit from home health services.

Home health services can be advantageous for all age groups, the young, as well as the old. The young, for example, may suffer emotional trauma when removed from their families for long hospital stays.

ALTHOUGH 71 COUNTIES in Michigan have home health agencies which provide two or more of the services, nevertheless, many people in Michigan still are not receiving home health care that they may need. Some patients are eligible for payment of services through Medicare and Medicaid; all patients are eligible for service regardless of their ability to pay.

Surveys have shown that although home health services are available, many persons in need of care do not know of the existence of such services. Although the success of the home health service program in any community depends in large measure upon the ability and the enthusiasm of the health service professionals, and the support of business, social, and civic groups, its success depends primarily upon the cooperation and appropriate referral from the physician.

Further information regarding home health services in your county may be obtained from your local health department or visiting nurse association. ☐

Auxiliaries Help Recruit

BY MRS. W. G. GAMBLE, JR.
PRESIDENT, WOMAN'S AUXILIARY

Meeting the health needs of the future through providing sufficient health manpower is perhaps the medical profession's greatest challenge, and it is a challenge that the Auxiliary whole-heartedly embraces.

Our efforts in this area have been numerous—last year the Auxiliary, through the county auxiliaries, distributed thousands of copies of *Horizons Unlimited* and other publications designed to encourage young men and women to enter the health field. We have a combined fund of nearly

Say you saw it in Michigan Medicine

$20,000 representing scholarships, loans, and loans outstanding to assist financially people preparing for health careers.

OUR MEMBERS have manned the Health Careers Mobile in its journeys throughout the state. They have helped with the organization of health career clubs in high schools all over Michigan. They have assisted with health career days in many counties in the Lower and Upper Peninsulas. They participated in the Michigan State Medical Society's project "Operation Billboard" to place 200 billboards throughout Michigan to promote health careers.

In December the Auxiliary took part in the First Annual Michigan Institute on Health Careers sponsored by the Michigan Health Council and related agencies. Intended as an information exchange between guidance counselors and representatives of health careers and persons working with health career recruitment, the conference was said to be extremely informative to all parties concerned.

ALL THESE THINGS the Auxiliary members have done, but their task is now far greater and more encompassing. It is estimated that by 1970 more people will be employed in health careers than in any other field, and one out of every nine high school students must enter a health career to fulfill the coming demand for health care. Our Auxiliary members are cognizant of these facts, and this year they are attempting even greater tasks in order to help fill the present and future need for health care.

Mrs. Jack E. Goodwin, Frankenmuth, is the Auxiliary's state chairman of health careers, and she urges physicians and their wives to remember the three R's of health career recruitment:

Recall adults who have been trained in health careers but who have not been active in the recent past and urge them to take the necessary refresher courses to enable them to begin practice again.

Review the education requirements in each field, realistically evaluating the needs of today and the training and preparation necessary to meet them.

Recruit people of all ages to the health professions and occupations. All methods must be used to make our recruitment efforts more effective. We must continue to use the tools that have been found useful as well as to seek new ideas and procedures that will improve our methods.

BY REMEMBERING AND applying the three R's, Mrs. Goodwin points out, the Auxiliary and the medical profession can further their aims and activities in health career recruitment. However, manpower is also needed for the recruitment effort, and we need the help of all doctors' wives. By working in the Auxiliary's career-recruitment programs and applying the three R's, the challenge of sufficient health manpower can in part be met. ☐

Yes, Write, Write To Your Congressman

BY VERNON V. BASS, M.D.
MDPAC CHAIRMAN

"Congressmen don't pay any attention to letters, do they?"

"Our congressman never votes our way, so why bother?"

"Our congressman always votes our way, so why bother?"

* * *

These are three questions that MSMS officers and staff members hear quite often. And they hear variations of these questions too as they effect the Michigan legislature.

The questions are posed in a recent issue of *Washington Report,* a newsletter of the Chamber of Commerce of the United States.

The Chamber answers are good and will help answer doctors who pose the same issues.

The *Washington Report,* in part, declared:

"Question:

"Congressmen don't pay any attention to letters, do they?

"Answer:

"Conferees heard actual conversations reported in which key legislators used the phrases, 'Well, judging from my mail . . .' or . . . 'My mail is running four-to-one in favor of . . .' to show that legislators do pay attention to their mail.

"They quoted legislators and journalists to emphasize that lawmakers are quick to spot a trend and quick to spot an informed letter-writer — especially one who represents a segment of the constituency they are anxious to please.

"Question:

"Our congressmen always vote our way, so why bother?

"Answer:

"Many provisions inpending legislation are not just black or white. Your congressman needs your opinion and your support. He will be getting opposition pressure too, and he's human.

"Congressional Action Committee members

swapped ideas, points of interest, ways in which the Chamber's legislative information materials (including Washington Dial) are used to keep members informed on breaking developments.

"More local chambers have begun the practice of putting policy positions down in writing for more effective communications. They are also combining communications efforts with trade associations for even more effectiveness.

"The conferences, hopefully, will assist local organizations to key efforts toward becoming effective voices for business and dispel the myth that they are 'only a lonely voice in the wilderness.'"

As an active member of the Saginaw Chamber of Commerce, I know first-hand that the Chamber political action program is effective. I would urge more physicians to participate actively in their own local chamber. ☐

On Writing And Reading Editorials

GUEST EDITORIAL
BY CHARLES SELLERS, M.D.
DETROIT

When an editor writes an editorial and permits its publication, he exposes himself to the various reactions that may arise within the minds of his readers.

On one hand, there may be mis-reading, misinterpretation, cynicism, bias, prejudice and even calumny either inherent or aroused in the minds of some readers.

On the other hand, there may be, on occasion, a certain amount of open-mindedness, understanding, appreciation and even accolade develop in the minds of other readers.

PROBABLY THIS IS true because the editorial writer is a human being and as such may be imbued with certain qualities, opinions and ideas that become apparent or seem to become apparent and result in such a wide range of appraisals. The reader, also being human, may possibly harbor certain feelings, attitudes and convictions that may influence his receptivity of such writings aside from purely subjective considerations.

Some old friends may receive editorials, that might prove to be less than the best, with graciousness and concede that they are acceptable considering our limitations. Such is not the case with most others. We cannot expect leniency from them for they have the privilege of expecting the best.

The writing of an editorial is a many patterned thing evolving around the personality, perception, insight and interest of the author concerning a particular theme or subject. To be worthy of publication, an editorial must of necessity be one man's opinion. It should be grounded on relative truth. It should be clear, concise, imaginative, instructive and above all provocative. It should attempt to arouse consent or dissent in the mind of the reader. If all editorials were innocuous, they would quietly pass into the limbo of the innumerable items that cross our desks and land unread in the round file.

PHYSICIANS ARE individualists, some rugged and some slightly less rugged and more compassionate of their fellowmen. Among the primary attributes of the good physician are a great curiosity about life and the living thereof, tolerance for the opinions of others without becoming too opinionated himself, an inquiring mind and an exceptional ability to formulate quite valid opinions and conclusions based on experience and evidence.

Since individual experience usually is dissimilar and evidence may be interpreted differently by each person, it is natural that editorial writings may arouse diverse reactions, recall various experiences and indicate conflicting evidence to readers with widely varied backgrounds and current interests.

Editorials should not be construed as joint projects. They should not be interpreted as the official voice of the society nor of the publication. They represent the point of view, occasionally tempered by the editorial board, of the individual author whose signature subtends.

Editorial writers have the privilege of an opinion. ☐

3A's of Involvement

BY WALTER F. STREMPEK, M.D., CHIEF
REHABILITATION SERVICES SECTION
DIVISION OF ADULT HEALTH
MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The following guest editorial was written after reviewing the 1967 Public Health Service Review of the "Health Consequences of Smoking."

The fact that there were 48,000 automobile deaths in 1965 in the nation is considered a tragedy.

The fact that there were 300,000 excess deaths associated with smoking in 1965 is viewed with apathy . . . indifference . . . complacency.

There are three levels of involvement: Awareness . . . Acceptance . . . Action. At what depth of involvement are you in the smoking-health issue?

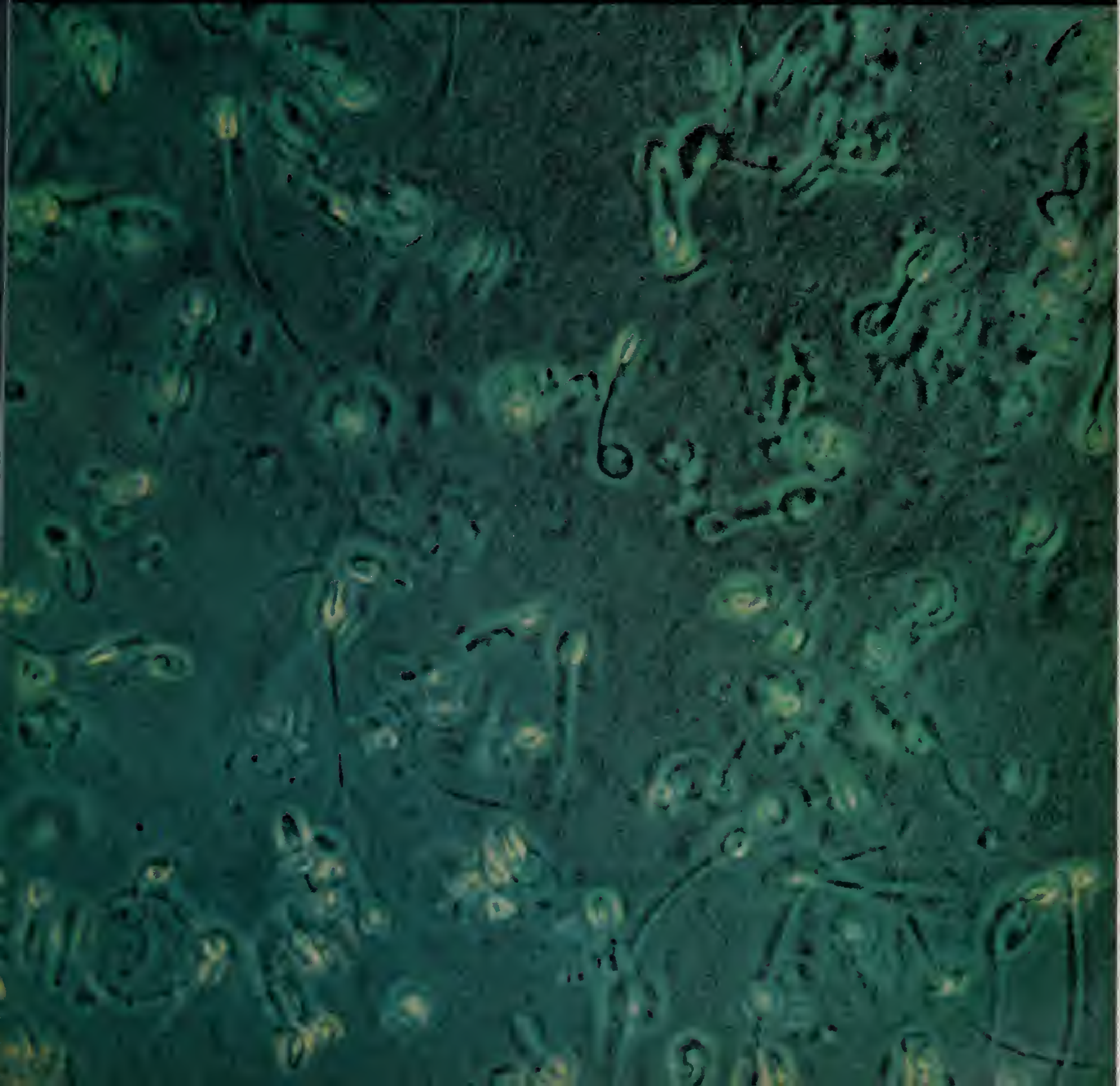
AWARENESS:—The majority of physicians are

Continued on Page 453

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

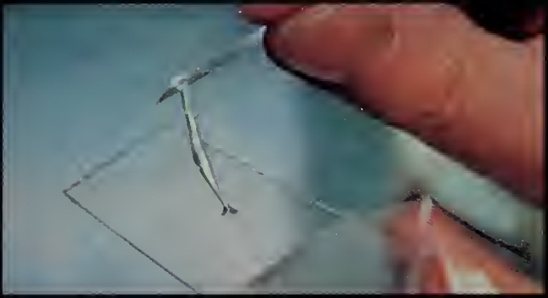
SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

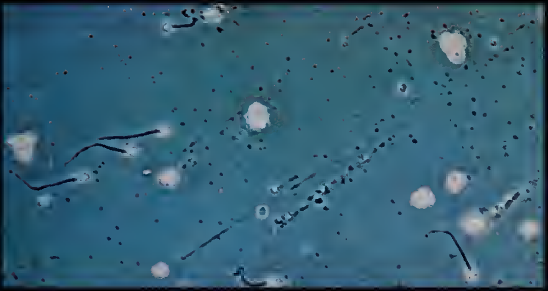
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

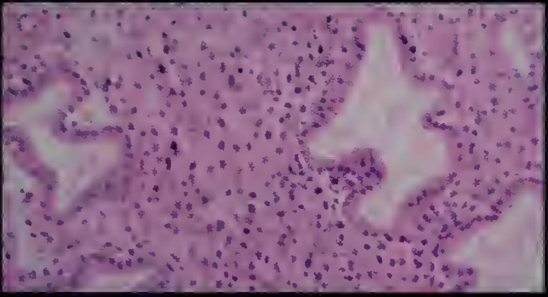
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

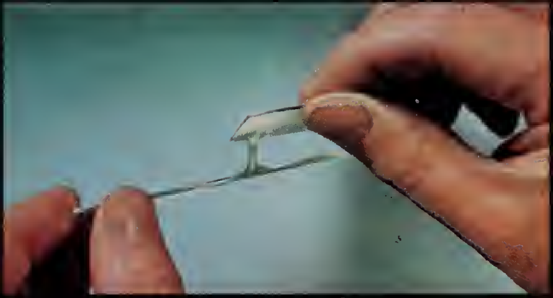


Spermatozoa appear healthy, active, freemoving.

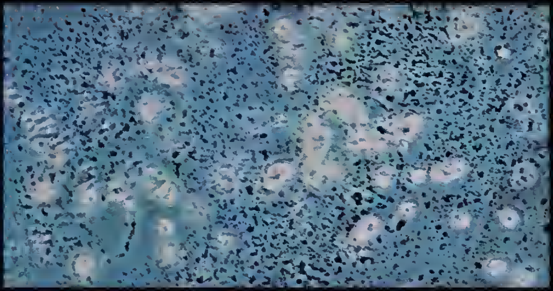


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

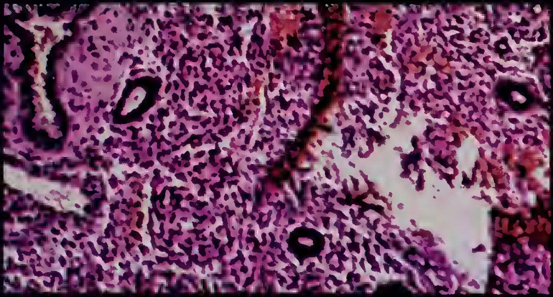
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.

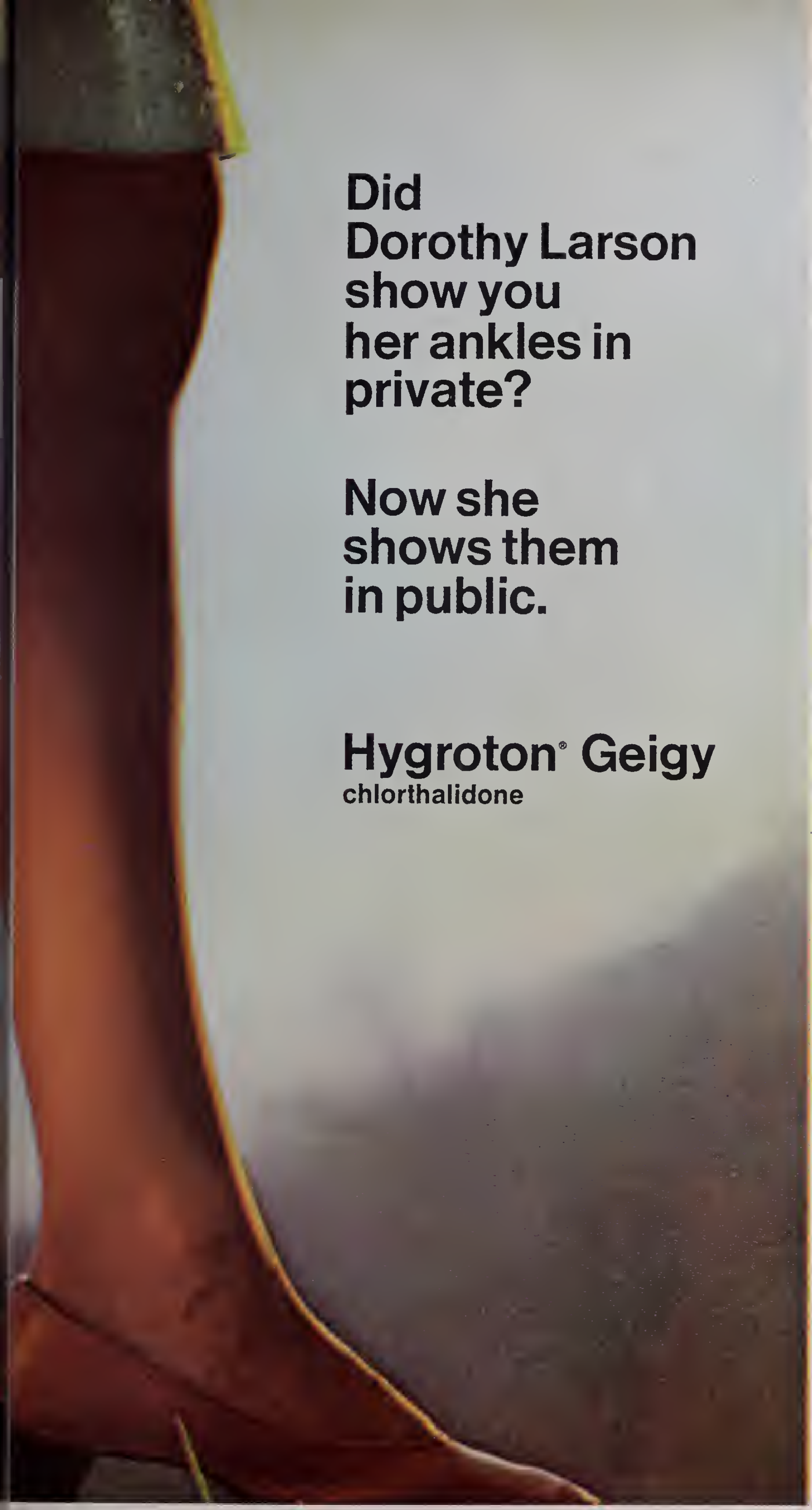


Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. c̄ mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progre sion of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN ris or liver dysfunction is aggravated Hepatic coma may be precipitate Electrolyte imbalance, sodium an or potassium depletion may occu If potassium depletion should occur during therapy, Hygroton shou be discontinued and potassium supplements given, provided the



Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton—to get rid of the edema.

And you found that Hygroton is not only effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

ent does not have marked oli-
a.
e special care in cirrhosis or
ere ischemic heart disease and
atients receiving corticoste-
ls, ACTH, or digitalis. Salt re-
ction is not recommended.
erse Reactions: Nausea, gastric
ation, vomiting, anorexia, con-
ation and cramping, dizziness,
kness, restlessness, hypergly-
ia, hyperuricemia, headache,
cle cramps, orthostatic hypo-

tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R46-230-D

For full details, please see the complete prescribing information.

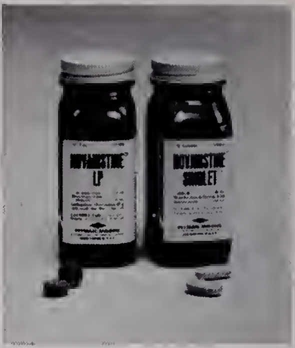
Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-5576 R

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

"Nothing else I've tried seems to work, so I decided to give you a crack at it."

aware of the innumerable articles and reports which have appeared over more than a decade in the medical literature, lay magazines, newspapers, etc. regarding the cigarette smoking problem. This culminated in "Smoking and Health," a report of an Advisory Committee to the Surgeon General of the Public Health Service, and associated cigarette smoking with higher death rates and death at earlier ages.

Another comprehensive critique of more than 2,000 research studies, "The Health Consequence of Smoking," a Public Health Review, 1967, has also been recently released and is recommended for your perusal.

ACCEPTANCE:—There can be no doubt that many physicians have accepted the evidence which incriminates cigarettes, for they have altered their behavior. A recent survey has revealed that the percentage of physicians smoking cigarettes has declined from 60 percent to 30 percent in recent years. This change in behavior of physicians was noted also in Britain and studies over a ten-year period (1951-56 and 1956-61) showed that there was a reduction in their standardized lung cancer rate during the time that lung cancer rates were rising in the male population of Great Britain. More recently, another report by Doll suggests that this trend is becoming more marked as the rate of smoking among British physicians continues to decline and the period of cessation of smoking increases.

ACTION:—Many physicians have taken action and stopped smoking cigarettes, but there remain more who owe themselves a penetrating review of the evidence.

Action requires education of, and support to the patient who wants to, or should be advised to cease smoking. Action requires support and involvement with the agencies and organizations endeavoring to give our youngsters all of the available information, and not just the "advertised glamour and adultness" of smoking before their "period of recruitment as new smokers."

Action also requires that all individual physicians; the MSMS, as the organized spokesman of Michigan physicians; and the AMA assume an active role in this vital issue through leadership and active participation in this campaign against the greatest man-made epidemic in medical history.

COMPREHENSIVE prevention of disease will be fundamental to the practice of medicine in the future. We have an opportunity to promote this by action in the present. ☐

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Doctors Are Needed On School Boards

BY H. J. HAZELDINE, M.D.
MEMBER, PORT HURON
BOARD OF EDUCATION

Because the medical profession is one of the most demanding of time and energy, doctors have intentionally avoided public service. I feel too, most doctors have used this as an excuse instead of a real reason to avoid civic participation. Some have felt that public participation on controversial affairs-such as political, federal, state, and local government-would harm his practice.

Despite all the negative reasoning, I feel a doctor has a special understanding to offer to community services and especially in the field of education. Due to his type of training in reasoning, he can make a great contribution to a board of education in analyzing and understanding the educational processes, needs and responsibilities to the people, students and educators. He can carry out a service to the board of education that few people can do. A doctor, because of the nature of his profession, has no personal axe to grind, therefore can function totally without business prejudices.

We must not forget that children are the most important natural resource of our country. It is important in this era of technology to understand that if we do not educate our children we will support them as drop-outs and as public liabilities.

When a doctor realizes this and serves on the Board of Education with this in mind, he will find it most rewarding to be contributing to what he feels is an important phase of our civilization.☐

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400,000 units of potassium penicillin V per teaspoonful

New…V-Cillin K®, Pediatric, 250 mg.

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The Medical Profession and the Public: An Examination of Interrelationships

BY ODIN W. ANDERSON, Ph.D.
UNIVERSITY OF CHICAGO

Introduction

A characteristic of the medical profession is its tendency to feel misunderstood.

In the art and the science of medicine the medical profession is accorded a great deal of necessary autonomy, but in methods of organization, delivery, and payment for their services they are likely to be accorded less freedom to follow their own predilections. In this country, however, the profession has always had more freedom in this regard than in other countries.

The profession's very freedom to determine both the art and science of medicine and methods of delivery until the recent past, tends to make it feel beleaguered and misunderstood when social and political forces impinge on their accustomed way of delivering services. Indeed, this separation may not even be possible, hence the profession is placed in the uncomfortable position of defending the status quo and slow change in the name of the indissoluble link of freedom and quality while at the same time being accused of extreme economic self-interest while doing so.

In this country self-interest is regarded as one of the strongest motives for self-advancement, hence the profession is caught in the toils of an over-simplified reason for behaving as they do.

THE PROFESSION HAS always been on the defensive everywhere when exposed to innovations in methods of delivery and payment for services. External stimuli have forced internal changes in methods of delivery and payment. The medical profession had not accepted new methods of delivery and payment until pressures were so overwhelming that the untenable alternatives of some kind of accommodation or capitulation were forced.

I stress the organizational aspects of the delivery of service and differentiate these from the art and science of medicine. In the latter, medicine has led and innovated. As a profession it could, of course, do no less if it were to function as a private self-regulating profession in a liberal and pluralistic society. Since the revolutionary change in the art and science of medicine brought about by scientific research, the issue has always been joined between society and the profession on methods of delivery and payment and not on the art and science of medicine.

The two segments are not mutually exclusive, they are interrelated. This, I believe, is the basis for the heated controversies regarding third-party payments, group practice, government intervention and the medical profession. The profession has exaggerated the intrinsic values of methods of delivery and payment to which they have been accustomed; the proponents of change have underrated the impact of new methods of delivery and payment on the traditional structure of medical practice, assuming that the change is merely one of source of payment.

THESE OBSERVATIONS ARE statements of fact and it would seem plausible interpretation, and as such are not meant as praise or blame. I assume it to be a truism that all human behavior takes place in some kind of social context of reciprocal relationships, that all behavior has intended and unintended consequences.

It is in this spirit I hope to examine the interrelationships between the medical profession and society from the latter Nineteenth Century to the present time with some glimpse into the future. I assume that self-knowledge is better than none, and that knowledge will result in more intelligent debates as to the issues and better articulated compromises between groups at interest than if sparring for position takes place in an atmosphere of mutual ignorance, misplaced pride, and recrimination.

If I cannot make this assumption then, indeed, the democratic process and rational social institutions based on knowledge and intelligent accommodations are impossible.

The Origin of the Current Structure Of Personal Health Services

Before medical practice was transformed by the medical scientific revolution at the turn of the century, physicians were engaged in private practice for fees from patients who sought their services. Physicians maintained their own offices. There were roughly as many, if not more, physicians in practice then in relation to population as there are now. Medical practice was part and parcel of a society in which private and individual enterprise was encouraged as the chief means of delivering and producing the goods and services that people desired.

The role of government was to maintain order, administer justice, assure a salubrious physical environment, defend the country against external enemies, facilitate interstate and international commerce, and provide in some way for the poor. There were, of course, exceptions but the latter Nineteenth Century in the United States represents as pure a laissez-faire concept of government and economy as has existed anywhere.

IN THIS CONTEXT A RAPIDLY expanding middle and upper income class and a relatively small poverty class were able to provide a source of livelihood for many medical practitioners. Hence, solo private practice, fee-for-service, and free choice of physician became characteristics of medical practice in Western Europe, Great Britain, Canada, and other Commonwealth countries, but particularly in the United States. This country was able to support a relatively large and viable private practice system.

Antisepsis and anesthesia were two specific medical factors influencing the growth and development of the general hospital during the latter part of the Nineteenth Century and into the Twentieth Century. Although surgical technique was already quite highly developed before the last quarter of the Nineteenth Century, large scale application was not possible because of the extremely high rates of postoperative infections, and the crude or nonexistent methods to alleviate pain. Antisepsis and anesthesia made the hospital and surgery both safe and relatively painless. A great many hospitals were capitalized by philanthropic and other private funds as gifts to the public welfare.

The result was the creation of the voluntary hospital system which to this day remains the backbone of hospital care in this country. The voluntary and general hospital became community-oriented hospitals immediately, serving both charity and private pay patients. In the main, separate hospitals for charity patients and private patients did not become an American pattern. The voluntary hospitals received the bulk of their income from pay patients. Some of this income was used to subsidize charity patients, and the rest

Among the Predictions by Professor Anderson:

"The balancing of professional prerogatives and patients' financial prerogatives will be the predominant concern of public policy regarding medical care for some time to come."

"Insurance benefits must be improved and such improvements will bring all physicians more and more into the orbit of third-party payments."

"An increasingly higher proportion of physicians' income will come from insurance agencies and government, but particularly insurance."

"Physicians will face increasing pressures to standardize their fee schedules and establish visible top limits."

"The trend toward salaried positions and group practice will continue."

"There will be an increase in the number of full-time hospital chiefs-of-staff."

"There will continue to be increasing interest in some form of utilization control mechanism in hospitals."

"Pressures on the medical profession will persist."

of the income for such patients came from philanthropy and government.

AT FIRST, THE GENERAL hospital was primarily a facility for surgical patients. The hospital made arrangements with surgeons to admit their private patients. The hospital charged the patient for a daily rate for room (American plan), general nursing, and ancillary services such as the operating room. The surgeon charged the patient directly for his services. Hospital admission privileges were much sought after by surgeons as a place to improve their skills in connection with free services to charity patients. The surgeon maintained his own office outside of the hospital.

Eventually medical patients in increasing numbers were admitted to the hospital with the same arrangements between the physician and hospital. And still later maternity patients were admitted to hospitals in large numbers. Thus emerged the current and prevailing structure of hospital and physicians' services, physicians remaining as autonomous practitioners with co-equal status among those who had hospital practice privileges.

The fee-for-service method of payment continued as the prevailing and almost exclusive method, and physicians remained autonomous individual practitioners largely in individual offices.

IT IS THUS SEEN that the structure of hospital and medical practice grew up spontaneously within the conditions present in the United States at the turn of the Century, and the adjustments and accommodations that seemed to be quite natural. The prevailing philosophy of the role of government and inherent in that philosophy the great reluctance to levy taxes gave the private and nonprofit sectors an area to develop and expand as seemed quite natural within the American context of the period.

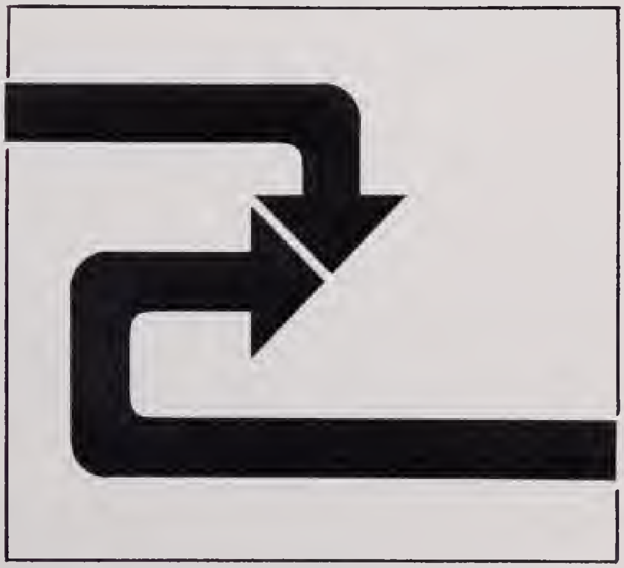
The medical scientific development alluded to previously was absorbed gradually but steadily into the medical practice structure once the medical schools became associated with the universities after the Flexner report released in 1910. This report was sponsored by the Council of Medical Education of the American Medical Association.

Further, the state licensing boards agreed to license only the physicians who were graduates of medical schools accredited by the American Medical Association. Thus, the new knowledge and the graduates of the improved and remaining medical schools (reduced from 160 to 80 between 1910 and 1915) were fed into the existing hospital and private medical practice structure. The medical profession accepted innovations in medical knowledge and technology rapidly. The hospital and medical structure described remained intact, and by 1920 the structure as it is now known reached its full development. Additions since this period have been refinements and filling out of the structure as it appeared around 1920.

Between 1915 and 1920 an innovation in the source of financing was supported in 16 states, by middle class and educated social reformers who had been active in promoting workmen's compensation, child labor laws, improved working conditions, public health programs for mothers and infants and related reforms.

There was agitation for some form of government-sponsored and supported health insurance plan for the entire population in order to assist workers and their families in paying for the hospital and physicians' services. The imposing hospital and physician services' edifice had been raised, and it was now realized that it was difficult for families to pay for these services as needed and used. The American Medical Association and state medical societies in the states concerned, the insurance industry, and other business groups opposed these reforms.

Further, organized labor was apathetic and by 1920 this particular innovation in financing health



services, copied from Germany and Great Britain, got nowhere. In 1920 the American Medical Association passed a resolution proscribing all forms of government support for health services except traditional public health programs, services for the indigent, and special groups like Veterans. It is not coincidental that the AMA by 1920 had over one-half of the physicians in the country as members.

THE SECOND ATTEMPT at innovation in financing of hospital and physicians' services took place in the Thirties, starting with insurance covering hospital care and sponsored mainly by the hospitals and hospital associations, and later for physicians' services sponsored by the state and local medical societies. The medical profession preferred a "wait and see" policy regarding the hospital insurance plans fearing that the hospital prepayment plans might be insolvent, and being quite skeptical of an enterprise not controlled by medical professionals. Latent was the constant uneasiness regarding the ever-present possibility of third-party interference with medical practice.

In the latter Thirties, medical societies from coast to coast sponsored and organized medical prepayment plans to help families pay for physicians' services mainly in the hospital. These were stimulated by the successful operation and expansion of the hospital plans, but particularly by the impetus given by the passage of the Social Security Act in 1936 to some form of federal-state health insurance system embodied in the series of Wagner-Murray-Dingell bills introduced in Congress from 1939 on.

THE MEDICAL PROFESSION was able to accept innovations in the science of medicine readily, but was not willing to accept innovations in methods of paying for physicians' services. Hence, voluntary health insurance has been a defensive action on the part of the profession, and hence, also, aggressive leadership has been lacking. Private insurance companies, in a sense, and very likely much to the relief of the profession filled the slack left by physician-sponsored medical plans and became an important complement to medically-sponsored plans.

Concurrently, another innovation concerned the organization rather than the financing of physicians' services. The organized medical profession expressed little enthusiasm for the principle of group practice preferring the individual physician, fee-for-service structure that had evolved during the latter Nineteenth Century and solidifying in the Twentieth.

The issue was joined, however, when in the latter Thirties and Forties several medical groups were established with prepayment added. Rather bitter court fights took place in which the medical profession was accused of restraint of trade because group practice physicians were unable to acquire hospital privileges in community general hospitals. There were also internecine battles generally. These organizational innovations were sponsored by physicians, interested laymen, and consumer organizations but these physicians were deviants from the mainstream of the medical profession in their concept of methods to deliver services.

IT IS NOT MY INTENTION to imply that the initial opposition to the financing and organizational innovations were carried out in bad faith. I simply assume that the opposition and reluctance to change were based on the profession's perception of what it felt was in the best interest of the patient and medical practice. I take their reasons at face value. Their subsequent accommodations to methods of financing and to some degree methods of organization are a matter of record.

What I do find impressive bordering on the awesome is the tenacity with which the profession holds to the time honored values of autonomous and individual practice and fee-for-service method of payment.

I cannot write off these deeply-held values as being whimsical or selfish although methods used to stall innovations may have been ill-advised. All professions entertain certain methods and contexts in which to function according to its most deeply held intuitive feelings. In any case, the medical profession has succeeded in maintaining the essential features of the traditional structure of medical practice intact, and insurance agencies have had to accommodate this structure as much as medical practice has had to accommodate to them.

During the last 30 years the health services structure has absorbed a tremendous increase in use of hospital and physicians' services, hospital and physicians' use have doubled. The expenditures for these services and the expenditures for capital financing of both hospital facilities and physicians' offices have tripled and quadrupled. Clearly health services have been increasingly desired by the American people. By all standards, health services is a growth industry which is absorbing a larger portion of family income and gross national product.

Polar Models Of Delivering Physicians' Services

A common method of sociological analysis is to set up models which do not actually exist in their pure form, but which appear to lurk in the background as concepts and are used as reference points by proponents and opponents. In medical practice the two polar models in this country are so-called solo and individual practice and so-called group practice.

THE MODEL OF MEDICAL practice regarded as ideal by the great bulk of physicians in practice is the solo and autonomous physician in his own individual office, competing for patients on the basis of service (only to a minor degree on the basis of price), paid fees for each service directly by the patient as set by the physician.

Patients have free choice of physicians, and physicians can pick and choose patients in regard to their specialties, serving any patient who selects them and complies with their instructions regardless of race or creed, or income. Physicians attract clientele who provide a base of demand and income, and they establish a network of relationships with hospitals and other physicians in order to refer patients to the great range of specialties and facilities in modern medical practice. The physician is, of course, licensed by the state and is subject to liability laws regarding professional services.

The physician is a completely, free-standing and autonomous practitioner who determines his level of quality, volume of practice, and the nature of his fees. All this takes place, of course, within a range of community patterns and norms which are probably felt more than made explicit.

No third party in any direct sense involves itself with the physician and the patient. The physician prefers not to have a contractual arrangement with an insurance agency. His contractual arrangement is solely with the patient. This is the reason, it seems to me, why physicians were initially reluctant to endorse some form of insurance to assist patients in paying for physicians' services when medical costs are incurred.

THE IDEAL WORLD for the physician is an absence of third-party payors which seems to intrude itself in both quality and fiduciary relationships between the physician and the patient. Obviously, this kind of a model is loaded on the side of the physician, because as has been shown repeatedly, the patients' needs for services vary considerably from year to year and sometimes upset seriously the family budget; hence insurance, and the adjustments this model of medical practice has had to make.

It seems that the medical practitioner does not differentiate between methods and amounts of payment on the one hand and professional prerogatives to diagnose and prescribe as he sees fit on the other. The practitioner seems to regard

AUTHOR

Doctor Anderson is Professor and Research Director, Center for Health Administration Studies, Graduate School of Business, The University of Chicago.

both of these as fundamental and interrelated prerogatives of professional freedom.

The other polar type is a group of physicians of sufficient number and variety of specialists to provide the full range of modern physicians' services from one center and also closely affiliated with a hospital. Further, such group is associated with an insurance plan which through a pooling of funds pays for all physicians' services; there is no charge at all to the patient at time of service.

Physicians are on a salary and one of the assumed advantages of this arrangement is that physicians can divorce costs from service, and hence prescribe what they feel is best for the patient regardless of cost in a particular instance. The patient selects the group and not a physician in the group, and therefore, relates himself to the institution. This does not preclude continuous relationships between some physicians and patients, but I am describing the logical end result of this type of system.

The physicians in a group have a great deal of the medical armamentaria on the spot; the solo practitioners refer to other physicians and medical equipment in the community at large. It is obvious that the solo-practice system is highly structured. The solo practice system tends to be patient oriented rather than peer oriented, and the group practice system the reverse. This patient orientation is in regard to patient convenience and wishes rather than to quality of care. The solo practice system is more manipulable by patients, but the group practice structure is easier for patients to use once they are in the system. This is admittedly a very brief description of a very complex subject.

Prevailing Range of Alternatives

It is quite literally possible today for a physician to engage in a type of practice ranging between the polar types described in the previous section.

Many kinds of combinations are possible. A physician can be engaged in solo practice and have an appointment as a part-time school physician or as a physician in an industry. A physician can be based part-time in a group practice prepayment type of structure and be a solo practitioner with his own office as well. A physician can be a member of a group and be paid according to his volume of work or be paid a salary. He can be on the faculty of a medical school and also be in private practice.

The combinations are quite endless. It is also clear that a physician can be paid by a variety of methods from fee-per-service to a salary. Some alternatives are easier to enter than others because of varying opportunities as seen in the distribution of types of practice.

THE FREQUENTLY OBSERVED changes in medical practice have been stupendous during the last 35 years; specialization has proliferated, source

Among the Observations by Anderson:

"It seems that the medical practitioner does not differentiate between methods and amounts of payments on one hand and professional prerogatives to diagnose and prescribe as he sees fit on the other."

"There seems to be a pervasive uneasiness, bordering on fear, with the gradual shifting of the source of payment from the patient to a third party."

"Review of practice in physicians' offices still seems remote since a great deal of medical practice necessarily takes place in private."

"I am quite skeptical of the ability of utilization review committees to control use effectively and equitably given current knowledge or even near-future knowledge."

"No other profession has as many alternatives open to it as does the medical profession to practice in a wide range of settings."

of payment from the patient to some type of third party has shifted greatly; the types of settings in which physicians serve have increased. Withal, however, it would seem that the structure of private practice which had been developed by 1920 still remains essentially intact. About two-thirds of physicians are in private practice (86% in 1931). More and more physicians are occupying research, teaching, and administrative positions, and may have extended their graduate training in residencies.

The main shift with the greatest implication for private practice, however, has been the source of payment occasioned by the rise of voluntary health insurance. The solo-practice fee-for-service method of payment still remains the dominant model of practice as measured by volume of patient care. The insurance mechanism has been grafted to this structure of practice. Important exceptions are the group practice prepayment plans, but so far they cover only about five per cent of the population. Their growth continues, but it is slow.

There is also a continuing growth in group practice units but best estimates currently would be that around 10 per cent of practitioners in this country are members of these units.

TODAY OVER 25 percent of physicians' incomes in private practice come from voluntary health insurance. The percentage varies considerably among physicians. Among surgeons it is almost two-thirds. General practitioners and internists earn very little from insurance, because insurance for physician services is designed mainly to cover in-hospital physician services. This is changing somewhat because of the gradual increase in the percent of the population covered by major medical type of insurance. Physicians' incomes in this system are by all standards very good — the net is now $26,000 a year or so — although the working hours are very long and the patient load heavy.

It should, thus, be clear that the current system gives the physician a tremendous range of alternatives and combinations of alternatives, as it also does for the patient who knows how to use the system.

It is, therefore, ridiculous to classify medical practice into solo and group practice, because they hardly exist in their pure form. Solo practice is mainly an economic concept in that the physician sets and collects his own fees from patients he cares for. Solo practitioners engage in a great deal of informal group practice by shared office resources and by referrals to other physicians, and can maintain a high degree of fluidity in how he calls on the facilities and other physicians in the community. Group practice is a formalized method of referrals within the same group.

In either case, however, no studies have been done showing how physicians refer to each other in the handling of cases. No studies have been made of a cross-section of practices and a typology of practices established.

A FINAL AND A summary observation is that physicians may be bewildered at the proliferation of practice sites and types open to them, but more deeply there seems to be a pervasive uneasiness, bordering on fear, with the gradual shifting of the source of payment from the patient to a third party.

There seems to be fear that third-party payments will erode the fee-for-service method of payment as it was known before insurance and that physicians will lose control as individuals over the amount of fees, and possibly, even lose some autonomy over their prerogatives of diagnosing and prescribing as they see fit.

THESE FEARS ARE NOT baseless, although they may be exaggerated. External conditions should, however, encourage physicians to re-evaluate what is meant by professional freedom in relation to the family's need for some method of paying for physician's service as it does for paying for other contingencies.

So far, it seems that physicians have really not understood the patient's financial problems (as distinct, of course, from his medical problems). I do not mean that physicians are not sympathetic with a patient's financial problems and would be willing to lower fees, stretch out the payment period, and so on. It seems, rather, that physicians still have difficulties in seeing medical costs as contingencies that occur more or less randomly in a population. They seem to prefer to assume full responsibility for how a patient pays for his care on a person-to-person basis.

The public resents being beholden to anyone, and prefers to pay their way. For medical services, insurance is the accepted method of paying for services.

THE BALANCING OF professional prerogatives and patient's financial prerogatives will be the predominant concern of public policy regarding medical care for some time to come. Up to now, the providers of service have determined their own destiny according to their own predilections and wisdom in a free-wheeling economy.

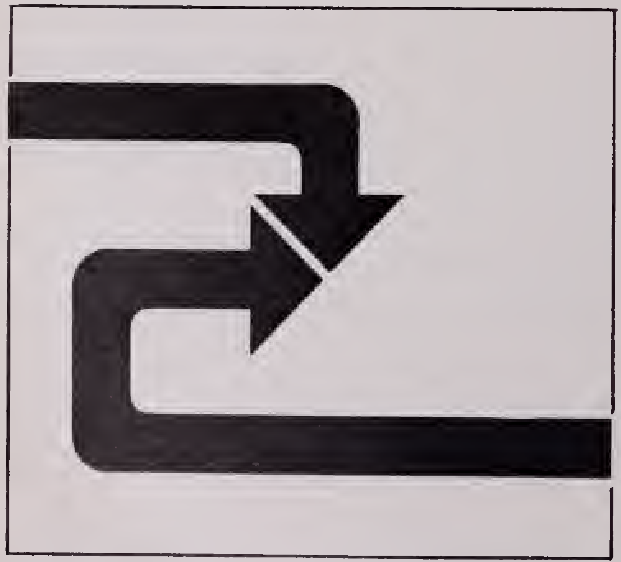
A health services establishment as measured by quality and quantity of facilities, medical educational institutions, physicians' offices, has emerged second to none in the world despite all obvious deficiencies.

A serious deficiency remains although it is gradually diminishing — the insurance benefits must be improved and such improvements will bring all physicians more and more into the orbit of third-party payments.

A subsidiary issue in my opinion, although given high priority by many others, is the reorganization of medical practice into some form of group practice.

How structured medical practice should be is a question discussed and debated at length.

By and large physicians are reluctant to enter into highly-structured practice situations. Again the issue is not clear cut solo-practice or group practice. It would seem that various measures can be taken to establish criteria of performance and standards for so-called solo practice acceptable to the profession generally. In passing, it can also be said that such criteria are not concrete for group practice situations either.



Future of Medical Practice

It would seem to be a reasonably sound prediction that general practitioners will continue to decline in proportion to all practitioners, if I define general practice as general physician care for the individual or family excluding obstetrics, pediatrics, surgery, and eye, ear, nose, and throat and all other specialties.

The question remains as to how small a proportion of all physicians will be comprised of general practitioners. One of the factors which will help to determine the proportion of general practitioners is the extent to which they will have hospital admisson privileges.

ANOTHER PREDICTION is that an increasingly higher proportion of physicians' incomes will come from insurance agencies and government, but particularly insurance. So far over one-half of physicians' incomes on an average are paid directly by the patient. Clearly, the family needs to have this portion reduced considerably, so that eventually possibly 80 percent or more of physicians' charges are paid by insurance.

Following from the foregoing, physicians will face increasing pressures to standardize their fee schedules and establish visible top limits. It is not reasonable for physicians to assume that when insurance and government guarantees payment physicians individually can charge variable fees as they see fit. The fee system of charging developed in a context of no nsurance. Large buyers require some guarantees of stable fees over periods of time. I do not suggest that insurance needs to pay 100 percent of fees; I am suggesting that whatever proportion insurance pays, the proportion the patient may be charged in addition should be a predictable one.

THE TREND TOWARD salaried positions and group practice will continue.

It is unlikely the pace will be as great as proponents predict and hope, or that even the majority of physicians in full-time practice will be so engaged. I cannot but be impressed by the apparent reluctance of physicians to practice in highly structured situations — excluding places like Mayo, teaching centers and so on — or of private patients to use clinic type facilities. As long as physicians continue to have the range of choice of sites, I would predict that the majority of physicians will continue to practice in individual offices or in small, flexible partnership units which can appear and disappear as partners see fit.

In line with the foregoing, I would suppose there will be an increase in the number of full-time chiefs-of-staff in hospitals, but other physicians will be affiliated more or less as they are now.

I frankly cannot predict, as so many do, that the hospital will be the center for *most* of the medical care in a community as long as physicians have the option of having offices, separate from the hospital although perhaps increasingly contiguous to or near the hospital. Although the hospital can muster greater technical resources and more control than a single physician or a small group of physicians, I would predict that physicians will counter the trend toward the hospital by providing their own offices with diagnostic and treatment equipment not necessarily associated with surgery. Physicians have the gross incomes and borrowing ability to invest in equipment which will not be as heavily used as it might be in the hospital. The economy will continue to be flush enough to tolerate this "waste" of resources or consumers with money will demand if service is more personal.

There will continue to be increasing interest in some form of utilization control mechanism in hospitals. Physician practice in hospitals will be scrutinized as to length of stay, procedures recommended, and perhaps, also, at time of admission. Review of practice in physicians' offices still seems remote since a great deal of medical practice necessarily takes place in private. Record keeping systems have to be exceedingly detailed to monitor what takes place in office practice.

I am quite skeptical of the ability of utilization review committees to control use effectively and equitably given current knowledge or even near-future knowledge. Nevertheless, review methods will likely be able to go so far before the profession reacts. The profession will continue to be very powerful in matters touching traditional professional prerogatives.

IN SUMMARY, THEN, it would appear to me that no other profession has as many alternatives open to it as does the medical profession to practice in a wide range of settings. They will continue to be in relatively short supply and high demand indefinitely, and therefore, will enjoy good incomes. They will have to make increasing accommodations in their fee-charging practices.

The American health services system will continue to be a loosely structured, fluid system for some time to come. Within this system physicians will have room to practice according to their preferences and predilections and consumer choices.

This guarded optimism, from the standpoint of the medical profession, should be tempered with the warning that pressures on the profession will persist. Accordingly, the profession will continue to feel misunderstood and even maligned at the same time that their services are increasingly effective and sought after.

Considering the options in methods of practice and promise of high incomes, it would seem that the profession will continue to enjoy a very tolerable way of life.

This article is the third in a series of original papers commissioned by the MSMS Committee on Medical Socio-Economics, Dale L. Kessler, M.D., Grand Rapids, chairman. The others were "The Outlook for Group Practice-Payment, Direct Service Plans during the Next 20 Years" by Caldwell B. Esselstyn, M.D.; and "The Future of Health Insurance, Prepayment and Medicine" by Charles P. Hall, Jr. The article by Temple University Professor Hall was later judged by the National Blue Shield organization as the most scholarly article printed in any medical publication during 1967 about socio-economic issues.

The Publication Committee welcomes comments on this third article.

Tuberculosis and Health Examinations Prior to Attendance at a Private Camp

ABSTRACT: Review of the health records of children at a private camp indicate a high degree of compliance with recent Michigan legislation regarding tuberculin testing of campers. Testing of camp personnel was less satisfactory. Further parent and physician education is necessary.

BY ROBERT A. GREEN, M.D.
ANN ARBOR

Michigan Act No. 169 of the Public Acts of 1966 indicates that persons in charge of a children's camp shall have on file a statement signed by a licensed physician that each child has been immunized against the usual childhood diseases and tuberculin tested (or possibly x-rayed) as well. The tuberculosis examination should have been performed within the preceding 90 days. It is understood that the licensing section of the Michigan Department of Social Services requires camp personnel to meet similar regulations.

Camp officers thus have a clear responsibility to ask the parents of prospective campers to arrange with their physicians that these requirements be met prior to the start of camp. I had the opportunity to be camp physician at a private camp in northern Michigan primarily for Michigan residents of high socio-economic status during the summer of 1967, and was able to review the success of this venture into preventive medicine at this single camp.

Standardized health forms prepared by the American Camping Association were mailed to parents of all applicant campers. A line was added by the directors of the camp requesting information about the tuberculin test. The parents had two responsibilities: to fill out the campers' medical history and to sign an emergency operative permission statement. The examining physicians had three responsibilities: to record the physical examination, to record the immunization history and to indicate if a tuberculin skin test had been done. Similar forms were sent to the camp staff.

Result

Camp records indicated that 252 children had been at camp during the summer. Review of their health forms suggests that parents could have been considered delinquent in their responsibility towards their own children's health in 77 (35%) instances. No health record at all was on file for 20; no medical history was given in 34 and an incomplete history in 11; and the operative permission was not signed for 12, even after a second request to do so was made after camp began. In addition to the 232 identified records, four health forms were found which were completed but had no child's name on them. Of these one child was noted to be allergic to penicillin and another to sulfa.

The examining physician had completed the physicial examination form in all 232 instances, and a good immunization history was given in 227, truly an excellent record. The experience with tuberculosis control was poorer although still good (see table). Tuberculin skin tests had been done, one way or another, in 203 (80%), although a minority of these were within the three month period prior to the start of camp. It is of interest that of the 29 children in whom tuberculin skin tests had not been done six had physicians for

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TUBERCULIN SKIN TESTING OF 252 CAMPERS

No Health Record	20
No Tuberculin Test	29
Tuberculin Positive (On INH)	1
Known Tuberculin Negative (1966 or 1967)	89
Tuberculin Done, Presumed Negative	104
Tuberculin Done Prior to 1966	9

fathers, and of these six one father had taken an x-ray instead on his ten-year-old, one had performed tuberculins on other campers for whom he was the physician although not on his own child, and one child was a severe juvenile diabetic.

The experience with the staff of 93 was less satisfactory. No health form was available for 29. Only 43 were known to have had a tuberculin skin test done; one of these was positive, had not been recently x-rayed and was not on isoniazid.

A second provision of the law required the camp management to make available or report to the local health department the record of the immunizations and the tuberculin tests. The camp directors at our camp, and others with whom I spoke, were unaware of this provision, although clearly informed of and cooperating with the tuberculin requirements. No request for such a report was received from the health department.

Comment

I believe the requirement for tuberculin testing of campers is a well-conceived public health measure. Camp personnel should certainly be included, as are school personnel in a similar law, as the danger to children is greater from adults, who have a higher incidence of tuberculin positivity, than it is from other campers. The health department should make some provision for the reporting of the results of the tests if such is actually deemed necessary.

Lastly, further parent and physician education is needed if still better control is to be achieved.☐

Book Review

THE HUMAN ADRENAL CORTEX: ITS FUNCTION THROUGHOUT LIFE. (Ciba Foundation Study Group No. 27) Edited by G. E. W. Wolstenholme and Ruth Porter. 146 pp, Illustrated. Little, Brown and Company, Boston, 1967.

This is a brief volume of papers presented at a symposium in September, 1966. A much larger and more comprehensive volume on the same subject was published a number of years ago and the present one primarily reports advances in the last few years. These advances have been considerable although each author takes some pains to identify the still unanswered problems that are present. A list of those who presented papers and discussed them is quite impressive although one notices the absence of a few outstanding workers in the field, particularly those from the United States.

The material is presented largely in a chronologic fashion starting off with the function of the fetal adrenal and progressing to a paper entitled, "The Function of the Adrenal Cortex in Old Age." In addition, there is a discussion of the role of the adrenal cortex in pregnancy and presentations with regard to both acute and chronic stress. Although a few of the papers are of quite technical nature, the majority of material is quite easily read and should prove of considerable interest to anyone in medicine.

Among the discussions the reviewer found most interesting were those related to the function of the hypothalamus as the origin of pituitary stimulus and the use of the anencephalic monster to resolve some of the problems. It would appear from the work presented that the adrenal cortex is not essential for fetal survival. The newborn infant appears to be capable of producing very adequate amounts of the corticosteroids and the quantities found in the circulation are actually higher than later in life. One of the apparent reasons for this is because of an inability of the neonatal liver to metabolize these substances. The role of the adrenal in pubertal development is discussed.

An extremely interesting chapter discusses the interrelationship of the fetal adrenal, the placenta and the maternal organism. The synthesis of some of the estrogens, particularly estriol, is outlined and its measurement as a means of prognosticating pregnancy is presented.

The material on the response of the adrenal cortex to stress is well summarized but little really new material or new concepts are evident. It would appear from this review that the adrenal cortex remains responsive to stimulus well into old age.

As with other volumes from the Ciba Foundation, this one is very well edited anl physically is quite attractive. The diagrams and charts are well reproduced.

George H. Lowrey, M.D.
Scientific Editor

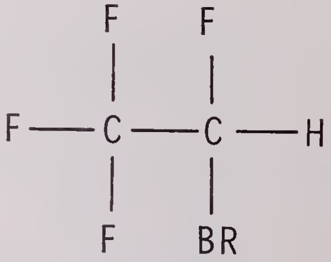
Teflurane:
A New Halogenated Gaseous Anesthetic — First Clinical Experience

EDITORIAL COMMENT: Search for the perfect anesthetic continues. The authors describe a new gas-type of anesthesia with many desirable attributes but also a disturbing tendency to induce cardiac arrhythmias of a transient nature. (Scientific Editor George H. Lowrey, M.D.)

BY KENNETH LEVIN, M.D.
GUENTER CORSSEN, M.D.
BOTH OF ANN ARBOR

In the continuing search for a non-flammable anesthetic gas with intermediate potency, a compound with the formula 1,1,1,2-tetrafluoro-2-bromoethane (teflurane) has recently been explored.[1] Teflurane belongs to the series of halogenated hydrocarbons (Fig. 1) of which halothane (Fluothane) and methoxyflurane (Penthrane) have attained wide approval as effective and safe anesthetic agents. Initial reports suggested that teflurane may offer some distinct advantages over other halogenated anesthetics.

Teflurane is a gas which eliminates the need for the vaporizers used with volatile anesthetic agents. Because of its low water solubility the onset of anesthesia is rapid, and emergence from anesthesia is equally fast. In addition, the gas has a pleasant odor and is not irritating to the mucous membranes of the upper respiratory tract, ensuring smooth induction of anesthesia. Also, cardiovascular and respiratory depression do not seem to pose any serious problem during light teflurane-induced surgical anesthesia.



$\mathrm{F{-}CF_2{-}CF(BR){-}H}$

Figure 1: Chemical Formula of Treflurane (Tetrafluoro Bromoethane)

Preliminary clinical exploration of teflurane was temporarily suspended when it was reported[2] that pathologic changes had occurred in kidney tubules of dogs anesthetized with teflurane for long periods. Further studies,[3] however, failed to confirm the findings of nephrotoxicity, and clinical studies with teflurane were resumed. A favorable account[4] of the use of this agent in approximately 150 patients seemed to confirm its suitability and usefulness in clinical anesthesia, and prompted us to initiate a clinical trial with teflurane in our institution.

Method

Teflurane was administered to 45 patients (20 male and 25 female) from 3 to 83 years old, who had been scheduled for elective surgical procedures. Table 1 lists the surgical procedures carried out under teflurane anesthesia. The length of operation ranged from ½ to 4 hours.

General surgery	23
Bone and joint	13
Genito-urinary	3
Neurosurgery	2
Ophthalmology	3
Otorhinolaryngology	1
Total	45

Table 1: Types of surgical procedures carried out under Teflurane anesthesia

Premedication consisted of atropine or scopolamine (0.1 to 0.4 mg) alone or in combination with pentobarbital (50 to 150 mg), depending on age and weight of the patient. The medication was administered intramuscularly, 30 to 60 minutes before induction of anesthesia. Five patients received in addition to this premedication, 1 to 2 ml. of droperidol given intramuscularly 60 minutes before surgery. In 7 patients the beta-adrenergic blocking agent propanolol (Inderal) was administered intravenously (1 to 2 mg) one minute before the start of anesthesia.

Blood pressure (inflatable cuff method), pulse, and respiration were checked before the start of anesthesia and every five minutes thereafter until the patient had awakened. The electrocardiogram (Lead II) was monitored continuously and recorded directly. For induction and maintenance of anesthesia, nitrous oxide-oxygen mixtures and teflurane were the only anesthetics used.

Induction of anesthesia was accomplished by administering 6 L/min. of nitrous oxide and 2 L/min. of oxygen by mask via a semi-closed, circle filter, carbon-dioxide absorption system. One to three minutes after the administration of nitrous oxide oxygen had begun, teflurane was added to the inhaled mixture at a flow rate of 100 ml/min. Every 30 seconds the rate was increased by 100 ml/min. until the flow of teflurane had reached 600 ml/min. with nitrous oxide and oxygen administration continuing at the initial rates. The nitrous oxide flow was then reduced to 3 L/min. and the flow of oxygen increased to 3 L/min. providing a 50:50 mixture of nitrous oxide-oxygen with 600 ml/min. of teflurane (10%). After administering this mixture of nitrous oxide-oxygen and teflurane for 1 minute, succinylcholine (60 mg) was given intravenously to facilitate the orotracheal intubation which was carried out in all patients. For maintenance of surgical anesthesia the administration of nitrous-oxide oxygen was continued at 3 L/min. each with teflurane added to this mixture at rates of 100 to 300 ml/min. In most cases the patient was allowed to breathe spontaneously with the respirations assisted; when muscle relaxants were used, the respirations were controlled.

Muscle relaxants during maintenance were used in 10 patients (9-d-tubocurarine, 1-gallamine) to provide adequate relaxation of abdominal muscles.

In 5 patients the cardiac output was determined (cardiogreen dilution method) before anesthesia (control), 5 to 10 minutes after endotracheal intubation when the patient appeared to have stabilized in surgical anesthesia, and immediately after the patient had awakened from anesthesia. At the same time, arterial PO_2, PCO_2, and pH were determined in 15 patients (radial or brachial artery).

In the early postoperative period patients were observed for recovery time. A patient was considered awake when he was responding to commands and was oriented as to person, time, and place. All patients were interviewed on either the evening of the operative day or the first postoperative day.

TEFLURANE

ARTERIAL PO_2, PCO_2 and pH

Pat: M.C., 85 year female, Removal Femoral Head (rt.)

	pH	PO_2 (mm/Hg)	PCO_2 (mm/Hg)
CONTROL	7.42	60	40
DURING SURGERY	7.47	200	38
POST OP.	7.42	80	42

Table 2: Arterial Po , Pco_2, and pH Before, during and after teflurane anesthesia

Results

With the exception of 6 patients, induction with teflurane was smooth and uneventful. As a rule, consciousness was lost one minute after teflurane had been added to the inhaled mixture at flow rates of 100 to 150 ml/min. Surgical anesthesia was established within 3 to 6 minutes with flow rates of teflurane ranging from 300 to 600 ml/min. There was no coughing, breath-holding, or evidence of upper airway obstruction. In all patients of this series an orotracheal tube was placed with the aid of intravenous succinylcholine.

Arterial blood gas analysis and pH determinations revealed values which ranged within physiologic limits indicating adequate respiratory exchange. A typical patient's record is shown in Table 2. It should again be pointed out that spontaneous and unassisted ventilation was not relied upon, but respirations were either assisted or controlled.

Muscle relaxation: Relaxation of the head and neck musculature appeared to occur early during induction. Abdominal muscles did not seem to relax adequately for carrying out intra-abdominal procedures unless muscle relaxants were employed.

Cardiovascular System: The cardiovascular system appeared stable, as reflected by the blood pressure values which did not significantly change during the course of anesthesia. In only 4 patients

(9%) a temporary fall in systolic and diastolic levels occurred. The pulse rate did not change significantly in 39 patients.

Cardiac arrhythmias of the ventricular and supraventricular type occurred in 32 patients. They were observed predomininantly in connection with orotracheal intubation but were also recorded during induction and maintenance of anesthesia and the recovery period. Figures 2, 3, 4, and 5 show the types of arrhythmia which were noted.

The occurrence of cardiac arrhythmias appeared to be related to the concentration of teflurane inhaled. At 10% teflurane, as used at the end of induction before the endotracheal tube was placed, cardiac arrhythmias occurred in 58% of the patients. Immediate reduction of teflurane to 5% or less resulted in spontaneous cessation of cardiac irregularities within 30 seconds to 3 minutes. However, in 7 patients (15%) arrhythmias persisted for 3 to 5 minutes despite the administration of oxygen with the flow of teflurane shut off.

There was no indication that the use of the alpha-adrenergic and antiarrhythmic agent droperidol given as preanesthetic medication influenced the occurrence of arrhythmias, since in all 5 patients in whom droperidol was used, cardiac irregularities were recorded. With the beta-adrenergic blocker propanolol, arrhythmias mostly of the supraventicular type occurred in 4 out of the 7 patients. Propanolol itself was not without hazard since it produced severe bradycardia in 3 patients and asystole of 6 seconds duration in 1 patient (see Fig. 6).

Surprisingly, the cardiac output determinations carried out in 5 patients revealed a reduction of cardiac output during surgical anesthesia in all five instances, the average decrease being 18.3% (Table 3).

CHANGES IN CARDIAC OUTPUT

Pt. #1.	(—) 14.8%
2.	(—) 18.2%
3.	(—) 12.3%
4.	(—) 30.5%
5.	(—) 15.7%
Average	(—) 18.3%

Table 3: Changes in cardiac output during teflurane anesthesia.

Emergence: Emergence from anesthesia was quick and smooth. Of the 45 patients, 40 awakened on the operating table 1 to 3 minutes after teflurane was discontinued, and the other 5 were awake within 5 to 10 minutes. Some of the patients appeared to be euphoric for a short time immediately after awakening. Nausea and retching occurred in 8 patients, of whom only 3 actually vomited.

Discussion

Teflurane is a potent and effective anesthetic agent. Surgical anesthesia is produced in concentrations ranging from 6 to 8 volumes percent combined with nitrous-oxide,oxygen. It appears that this non-explosive, non-flammable gas resembles cyclopropane in many aspects, except that the latter is explosive and flammable. Teflurane is non-irritating to the mucous membranes of the respiratory tract and is pleasant to inhale. Induction is smooth and rapid; excitement is rarely seen. Because of the drug's low water-solubility, saturation of the tissues is rapidly achieved and maintenance concentrations can be kept low. Overdose can occur quickly, however, because only

CO-AUTHORS

Doctors Levin and Corssen are both associated with the Department of Anesthesiology of the University of Michigan Medical School.

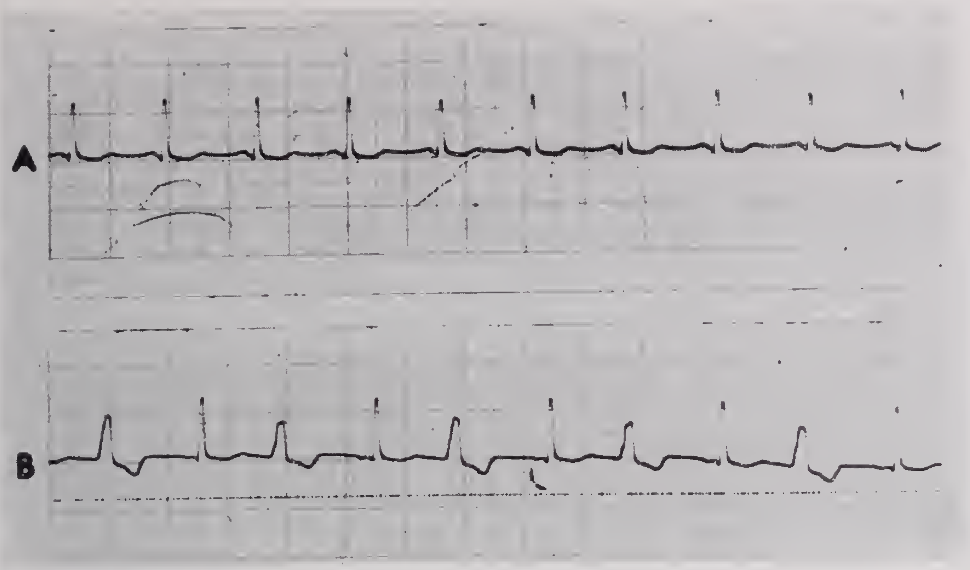


Figure 2: Pat. J. S. (#7), 53 year male; Op. Procedure: Incision and drainage of abscess R. Buttock. A. 9:30 a.m. — control, Pat. awake. B. 9:40 a.m. — induction with N_2O-O_2 (6:2 liter/min) - teflurane 400 ml/min. (Pat. in light surgical anesthesia). **Note:** Bigemini.

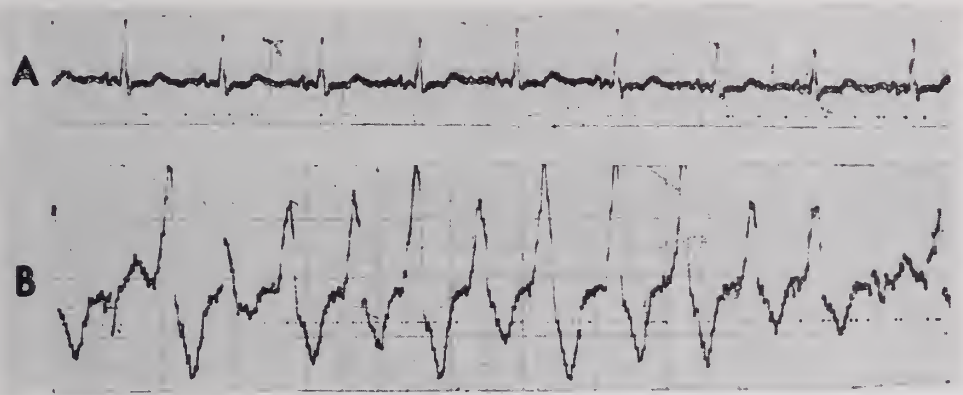


Figure 3: Pat. F. C. (#14), 51 year female; Op. Procedure: Excision of Clavicle. A. 10:29 a.m., control, Pat. awake. B. 10:36 a.m., placing endotracheal tube, N_2O-O_2 (3:3 L/min.), treflurane 600 ml/min. **Note:** Ventricular tachycardia.

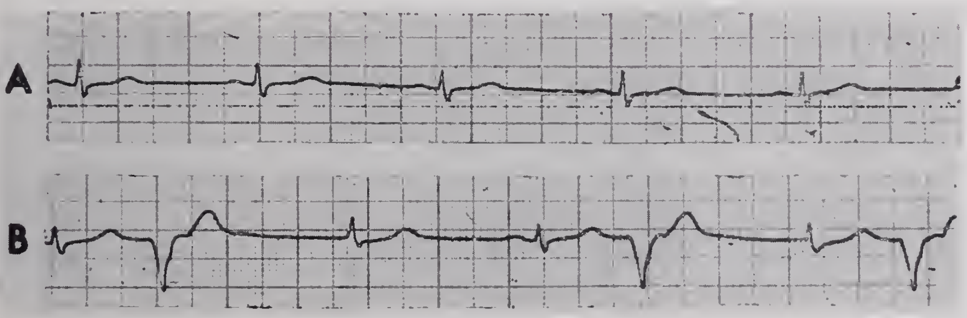


Figure 4: Pat. L. B. (#13), 57 year female; Op. Procedure: Retrogasserian Rhizotomy. A. 7:54 a.m. End of Induction, N_2O-O_2 (3:3 L/min.), Teflurane 600 ml/min. B. 8:20 a.m. Dissecting around Gasserian Ganglion, N_2O-O_2 3:3 L/min; teflurane 400 ml/min. **Note:** Premature ventricular contraction and Nodal rhythm.

small increases in the concentration of teflurane in the inspired mixture may lead to a rapid increase in the partial pressure of the gas in the tissues. Unlike cyclopropane, teflurane induces only minimal relaxation of muscles.

With the onset of surgical anesthesia, respiratory function appears to undergo a slight depression which increases with increasing depth of anesthesia. Therefore, spontaneous respirations should be mechanically assisted, and if muscle relaxants are required, the respiration should be controlled to avoid respiratory acidosis and anoxemia.

Emergence from anesthesia is usually rapid. The patient is immediately alert and oriented in less than 10 minutes after teflurane is discontinued. As with cyclopropane, patients emerging from teflurane anesthesia invariably complain of pain early in the postoperative period. Postoperative vomiting is rarely observed.

Artusio and his co-workers[1] suggested that the high incidence of arrhythmias observed in their early clinical exploration of teflurane may have been due to inaccurate metering of the gas through the cyclopropane flowmeter, with resultant unrecognized overdosage of the agent. In our own experience with a limited number of clinical cases, it has been apparent that even with accurate metering devices specifically designed for the administration of teflurane, the incidence and severity of arrhythmias have been significantly high. Antiarrhythmic medication did not significantly alter teflurane-induced cardiac irregularities. Neither the alpha-adrenergic blocking agent droperidol nor the beta-adrenergic blocking agent propanolol significantly influenced cardiac arrhythmias. There was some indication, however, that with propanolol, the arrhythmias tended to be supraventricular rather than ventricular. It should be pointed out that propanolol is a powerful myocardial depressant and its administration intravenously can result in severe bradycardia and even asystole, as described above.

Once arrhythmias occurred, regardless of whether the changes were recorded in connection with surgical stimulation or orotracheal intubation or were obviously the result of a higher concentration of teflurane, a reduction in the concentration of teflurane in a few instances resulted in immediate reversal and return to regular cardiac activity; often, however, the arrhythmia persisted for several minutes before sinus rhythm was resumed.

The fact that teflurane reduced the cardiac output strongly suggests that it is not a beta-adren-

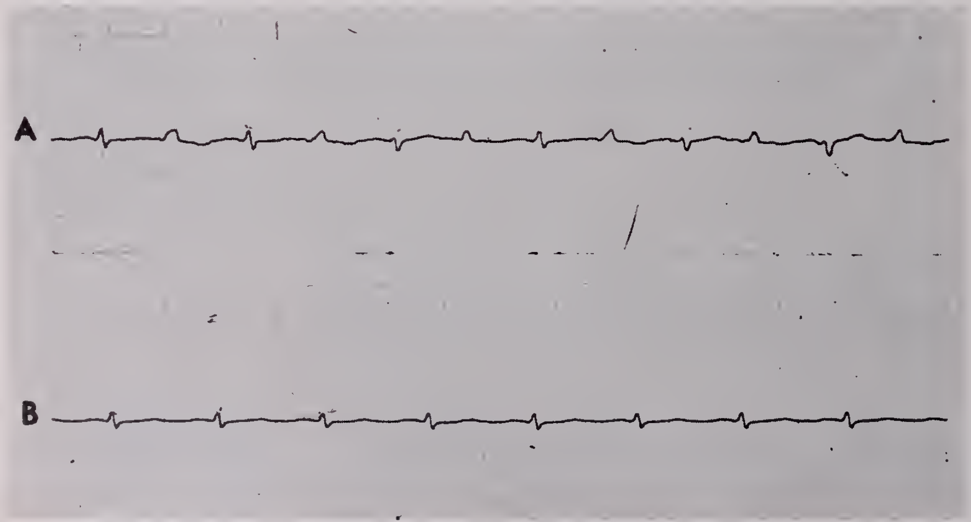


Figure 5: Pat. L. S. (#17), 56 year male; Op. Procedure: Repair Ventral Hernia. A. 3:30 p.m., maintenance with N_2O-O_2 (3:3 L/min), teflurane 300 ml/min. B. 3:50 p.m., surgery completed, N_2O-O_2 (3:3 L/min), teflurane off. **Note:** In spite of teflurane being discontinued, bigemini persist for 30 minutes.

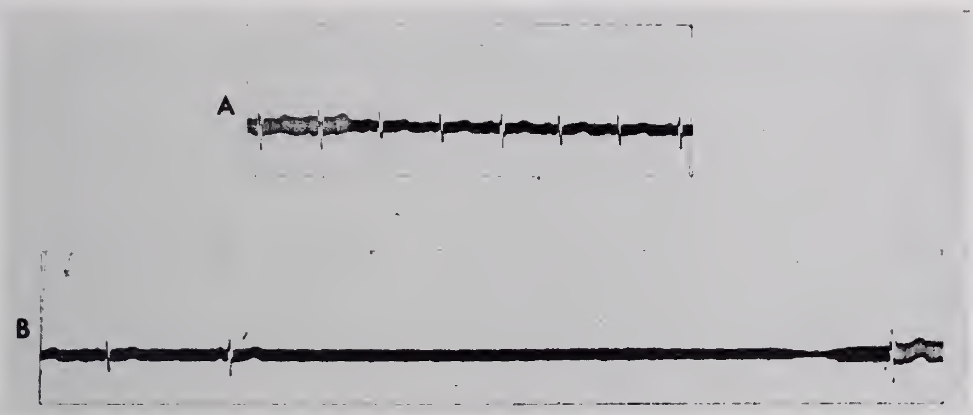


Figure 6: Pat. L. R. (#28), 4 year female; Op. Procedure: Tendon Graft. A. 11:45 a.m., induction with N_2O-O_2 (3:3 L/min), teflurane 500 ml/min. B. 11:51 a.m., induction; 4 minutes after propanolol (0.5 mg i.v.), N_2O-O_2 (3:3 L/min), teflurane 500 ml/min. **Note:** Asystole of 6 sec. duration.

ergic stimulant, which, in turn, may also explain why the beta-adrenergic blocking agent, propanolol, proved only partially successful in controlling or surpressing ventricular arrhythmias.

In conclusion it may be stated that teflurane is a potent anesthetic gas offering certain distinct advantages over some other conventional general anesthetics, including non-explosiveness, fast onset of action, rapid recovery, pleasant odor, circulatory stability, and minimal postoperative vomiting. The only significant disadvantage and potential danger in the clinical use of the gas is its arrhythmogenic property. Arrhythmias induced by teflurane cannot safely be suppressed by the use of potent antiarrhythmic drugs. Multifocal ventricular arrhythmias may occur not only with relative overdose of the agent but in concentrations of teflurane used for maintenance of surgical anesthesia.

Other means for effectively controlling teflurane-induced cardiac arrhythmias should be explored until this otherwise promising new halogenated anesthetic gas can be safely recommended for clinical use. ☐

Acknowledgement

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Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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Intermittent Corticosteroid Treatment Of Demyelinating Diseases in Childhood

BY D. B. BASU, M.D.
JOHN GILROY, M.D., F.R.C.P.(C.)
JOHN STIRLING MEYER, M.D.
ALL OF DETROIT

ABSTRACT: There is evidence that both ACTH and corticosteroids are effective in the treatment of a number of demyelinating diseases including multiple sclerosis. Treatment is often limited by the development of serious side effects. The use of methyl prednisolone or prednisone in a single oral dose once every 48 hours reduces side effects and permits long term administration of high doses if necessary.

It has been shown that the immunologic activity of both the reticuloendothelial system and of the central nervous system may be suppressed by treatment with Adrenocorticotrophic hormone (ACTH) or corticosteroids in experimental allergic encephalomyelitis.[1,2] Similar immunological mechanisms may be involved in demyelinating diseases in man. It was therefore postulated that ACTH or corticosteroids may benefit these conditions.

There have been a number of favorable reports on the use of ACTH and Cortisone derivatives in the treatment of some demyelinating diseases in man. Alexander et al.,[3,4] were the first to show a statistically significant degree of improvement in subjects with multiple sclerosis treated with high doses of ACTH (100 to 120 units daily for 10-20 days, then decreasing by 20 units every 2 to 5 days) when compared with an untreated group acting as controls. There seemed to be greater improvement in those showing maximal adrenal response to ACTH stimulation as measured by high urinary 17-Hydroxycorticoid levels. Serious side effects such as gastrointestinal bleeding, edema, infection, osteoporosis and electrolyte disturbances were encountered in many cases and present serious limitations to this type of therapy.

Glaser and Merritt, and Merritt, et al, also reported benefit from ACTH and cortisone in treatment of multiple sclerosis, particularly in reduction of spasticity, ataxia and impaired bladder function. ACTH was administered three or four times daily but frequent side effects were reported. In England, Miller and Gibbons,[5] reported improvement in some cases of acute disseminated encephalomyelitis treated with ACTH as early as 1953, and since then Miller, et al,[6] have reported favorably on the use of both ACTH and Prednisolone in the treatment of multiple sclerosis.

The purpose of this paper is to report beneficial results of treatment of two forms of demyelinating disease that affect children resulting in a fatal issue or serious neurological deficits. The disorders were post-infectious leukoencephalitis and Schilder's disease and the treatment consisted of high doses of corticosteroids given intermittently. Certain advantages of intermittent therapy with corticosteroids compared to the traditional divided daily administration of these preparations will be discussed.

Reports of Cases Treated

CASE I: A 10-year-old white female was admitted to Harper Hospital on December 4, 1964, with recurrent vomiting, expressive aphasia and paralysis of the right arm of three weeks' duration. The illness began with a febrile episode lasting 5 days, approximately one month prior to admission. There was no history of allergy to drugs or any other acute illnesses. The general physical examination was within normal limits.

Neurological Examination: She was oriented to time, place and person. There was slight difficulty in reading with paraphasia and difficulty in writing due to weakness in the right arm. She had nominal dysphasia. Cranial nerve examination showed bilateral optic atrophy with temporal pallor of the optic discs and paracentral scotoma. Muscle tone on passive manipulation of the limbs was increased in the right arm and leg. There was hemiparesis with severe weakness of the right arm and mild weakness in the right leg. A coarse, rhythmical tremor was noted in the right arm which was more evident in the proximal muscles. A slight tremor was also noted in the fingers of the outstretched left hand. There was dysmetria and intention tremor on finger-to-nose testing in both arms and the heel-to-shin test was clumsily performed on the right with dysmetria and ataxia. She required help to get up from bed and could stand with difficulty and walk a few steps with assistance but tended to fall to the left. All tendon reflexes were increased in the right arm and leg. The right plantar response was extensor and the left flexor. No abnormality was noted on testing sensation.

Laboratory Data: Lumbar puncture was performed. The initial pressure was 144 mm. of water. The cerebrospinal fluid was colorless and without cells. Protein content was 12 mgs. percent, sugar 73 mgs. percent and the chloride concentration was 123 meq/liter. Culture for bacteria and sereological tests for syphilis were negative. The colloidal gold curve was flat. Tests for metachromatic casts in the urine were negative. Shortly after admission to the hospital, the sodium content of the serum was 126 meq/liter. Potassium content was 3.8 meq/liter., chloride content was 93 meq/liter. and CO_2 content was 22.1 meq/liter. Subsequently, the serum electrolytes were restored to normal limits by appropriate intravenous fluids. The electroencephalogram showed normal alpha activity over the right hemisphere, but there was medium voltage slow activity in the theta and delta range over the left hemisphere. The blood count, culture and analysis of the urine, blood urea nitrogen, blood sugar, sedimentation rate, culture of the throat, blood culture, tests of the blood for febrile agglutinins, roentgenograms of the chest and skull were all within normal limits.

Clinical Diagnosis: A diagnosis of post-infectious leukoencephalitis was made based on the onset of symptoms of diffuse and patchy involvement of the central nervous system (left hemisphere, cerebellar and corticospinal systems and optic nerves) following a febrile illness.

Treatment: The child was placed on bed rest and given intravenous fluids. Methyl prednisolone (Medrol) was administered orally in the following dosage: 80 mg. every other day for eighteen days, 64 mg. on the twentieth and twenty-second days, 48 mg. on the twenty-fourth day, 32 mg. on the twenty-sixth day, 16 mg. on the twenty-eighth day and 8 mg. on the thirtieth day. The drug was then discontinued. After institute of therapy, progressive improvement was noted and by the time the course of treatment was completed the neurological examination was normal.

There have not been any symptoms for an interval of two years since discharged from hospital.

CASE 2: A 19-year-old white male was admitted to Harper Hospital on April 7, 1966, with a two month history of recurrent attacks of upper respiratory tract infections, sometimes accompanied with otitis media. Four days prior to admission, he awakened with a dull headache, nuchal rigidity, ataxia, dysarthria, nausea, blurring of vision, difficulty in reading and the complaint of numbness in both his hands and feet.

Neurological Examination: He was lethargic, but fully oriented with intact memory, speech, judgment and ability to read, write and calculate. The optic discs appeared moist and blurred at the edges. Vertical nystagmus was present and evidence of a bilateral inter-nuclear ophthalmoplegia with bilateral weakness and unilateral nystagmus of the abducting eye on gaze to either side. Bilateral ptosis was also present. There was weakness of the left lower face and the speech was dysarthric. The remaining cranial nerves were normal. The motor strength was normal. There was bilateral dysmetria and poor performance on tests of coordination in all four extremities and the gait was wide based and ataxic with a tendency to fall to either side. The deep tendon reflexes were slightly hyperactive, but both plantar responses were flexor. Pinprick sensation was diminished below both knees and both elbows.

Laboratory Data: The blood hemoglobin value was 13.96 gm. per 100 ml. with a hematocrit of 44.5%. The white cell count was 12,800 per cu. mm. with 64 percent polymorphonuclear cells, 15 percent band forms, 17 percent lymphocytes and 2 percent eosinophils. The sedimentation rate was 40 mm. in 1 hour. (Westergreen). The blood urea nitrogen content, fasting blood sugar level, serum calcium and phosphate levels, alkaline phosphatase level and serum protein electrophoresis were all within normal limits. Tests for serum heterophil antibodies, cold agglutinins and C reactive protein were negative. A lumbar puncture was performed on admission and showed normal pressures. The spinal fluid was colorless with 17 lymphocytes per cu. mm. The total protein was 30 mg. percent, the sugar content was 62 mg. percent and chloride content was 126 meq/liter. Serological tests for syphilis were negative and the colloidal gold curve test was flat. Bacterial cultures from the throat and from antral lavage revealed no growth.

For the first forty-eight hours after admission, the patient showed a progressive deterioration. He lost all visual percention in the left eye, and the funduscopic examination revealed evidence of papillitis due to optic neuritis. The left pupil reacted to light only on consensual testing. Cerebellar incoordination and intention tremor increased in the upper limbs and a sensory level appeared at T-4 with complete sensory loss below this level. A progressive paraparesis developed and the patient became unable to stand or walk with bladder paralysis and retention of urine requiring catheterization.

Clinical Diagnosis: The development of diffuse and patchy involvement of the central nervous system after a prolonged upper respiratory infection were judged to be characteristic of post-infectious leukoencephalomyelitis.

Treatment: Bed rest was instituted and methyl prednisolone (Medrol) 80 mg. was given orally every other day, from the fifth day following admission to the thirteenth day. The methyl prednisolone was then reduced to 64 mg. every other day from the fifteenth day of treatment and he was discharged on 48 mg. every other day on the twenty-first day. The patient improved progressively from the thirteenth day until he was discharged. There was a rapid return of bladder function and marked improvement in muscle strength in the lower extremities. His vision became 20/70 in the left eye without any visual field defect. He was able to walk with minimal ataxia.

Three weeks after discharge he was examined as an out-patient and there was complete resolution of symptoms and signs, and there has been no recurrence of symptoms in an 18 month period.

CASE 3: A 2½ year old white female was admitted to Harper Hospital on August 14, 1964, with an ataxic gait, paralysis of conjugate eye movements and lid retraction bilaterally. She had suffered from recurrent infections of the upper respiratory tract for approximately two months prior to admission. The general physical examination was within normal limits, except for a low grade fever.

Neurological Examination: Mentation was normal for her age. The visual fields were normal, but both optic discs appeared slightly swollen and blurred. Complete paralysis of all extraocular movements was present on attempted voluntary eye movements. Optokinetic nystagmus was absent in all directions. The remaining cranial nerves were intact. Tests for coordination showed moderate intention tremor and dysmetria bilaterally. Gait was wide-based with titubation of the head and marked truncal ataxia. The deep tendon reflexes were totally absent. The plantar responses were flexor. Motor strength and muscle tone were considered intact. Sensation was normal.

Laboratory Data: Lumbar puncture was performed on admission and the initial pressure was normal and the spinal fluid was colorless. There were 3 red blood cells, 7 lymphocytes and 2 polymorphonuclears per cu. mm. Cerebrospinal fluid

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MEYER

protein content was 29 mg. percent, sugar content was 60 mg. percent and chloride content was 121 meq/liter. Cultures for bacteria and fungi were negative. The total white blood count was 12,500 per cu. mm. with a normal differential count. The sedimentation rate was 20 mm. in 1 hour. (Westergreen). Roentgenograms of the chest showed accentuated lung markings at the right base, possibly due to pneumonitis. Analysis of the urine was normal. Blood and spinal fluid serological tests for syphilis were negative. Blood urea nitrogen, electralytes, calcium, phosphorous and alkaline phosphatase levels were normal. Culture of the throat was negative. Roentgenograms of the skull and the electroencephalogram were normal.

Clinical Diagnosis: The sudden onset of diffuse neurological signs, including optic neuritis, paralysis of extraocular movements and cerebellar dysfunction in a child following an upper respiratory infection were judged compatible with the diagnosis of acute post-infectious leukoencephalitis.

Treatment: Fever persisted for the first five days of her admission and Penicillin in dosage of 600,000 units per day were given because of possible pneumonitis. Her neurological status remained unchanged. On the fifth day in hospital, Methyl Prednisolone (Medrol) was given in doses of 80 mg. every other day. Marked neurological improvement began on the tenth hospital day. The optic neuritis resolved and normal extraocular movements returned except for slight limitation of upward gaze. The cerebellar incoordination rapidly improved. At the time of discharge there was minimal ataxia of gait and all truncal ataxia disappeared. Methyl Prednisolone was gradually withdrawn beginning on the eleventh day and was discontinued after the twenty-first day.

Repeated examinations in the out-patient clinic have not shown any neurological abnormality or recurrence of symptoms.

CASE 4: This final case in the series is believed to be a case of Schilder's disease in which several remissions have resulted coincident with institution of therapy with corticosteroids over a 4 year interval and maintenance dosage for the past 8 months are believed to have prevented further attacks. He has been seen in consultation by Dr. Manuel Gomez, Chief, Pediatric Neurology Section, Mayo Clinic, Dr. Richmond S. Paine, Chief, Neurology Department, Babies Hospital, Washington, D. C., and Dr. Paul Woolley, Professor and Chairman, Department of Pediatrics, Wayne State University, all of whom concurred with the clinical diagnosis of Schilder's disease.

A 3-year-old white male was admitted to Harper Hospital on August 15, 1963. His parents gave a history of an upper respiratory infection unassociated with fever which had been treated with antibiotics. About three days after treatment of the infection and ten days after the onset of upper respiratory symptoms, be became ataxic and complained of double vision. He was admitted to another regional hospital where urinalysis, skull x-ray and cerebrospinal fluid examination were reported to be normal. An electroencephalogram showed left frontal slowing. By the 7th day of the neurological illness, he was unable to walk, and fell to the left in attempting to stand. A ventriculogram was performed by a consulting neurosurgeon to rule out a posterior fossa tumor and this was found to be normal. There was some improvement over the next two months, but in November, 1963, he rapidly deteriorated. He became dysarthric and his ataxia increased so that he could only stand or walk with difficulty. The family had noted weakness in the left leg. He was admitted to the Neurology Service of Harper Hospital on November 12, 1963, with hemiplegia following a generalized epileptic seizure.

Neurological Examination: The patient was drowsy, but after two hours of postictal sleep, he became alert and was oriented as to place and person. He had bilateral optic atrophy with pallor of the discs. The other cranial nerves were normal. He was unable to stand on either leg and the right leg was weak in all muscle groups. There was cerebellar tremor in both upper extremities. The right knee jerk was absent but other tendon reflexes were symmetrical and normal. Both plantar responses were flexor and the sensation was normal.

Laboratory Data: On lumbar puncture, the opening and closing pressures were normal and spinal fluid showed 4 lymphocytes per cu. mm. The Pandy was negative and the total protein content was 95 mg. percent. A complete myelogram was normal. The electroencephalogram showed diffuse symmetrical medium voltage theta activity without lateralization. An electromyogram and nerve conduction time were normal. Skin and gastrocnemius muscle biopsy were normal.

Treatment: He was treated with Phenobarbital for the seizure for several days. This was discontinued because of hyperactivity and sodium diphenylhydantoin (Dilantin) 50 mg. four times daily was substituted. He was given a three week course of methyl prednisolone (Medrol) 20 mg. every other day with marked improvement beginning after 5 days. At the time of discharge he was free of neurological signs and symptoms except for temporal pallor. He was readmitted on September 17, 1964, following a clonic seizure involving the left face, arm and leg which lasted about forty minutes. He had shown deterioration in vision and coordination for about two weeks preceding the seizure. He was treated with sodium diphenylhydantoin (Dilantin) 100 mg. and Phenobarbital 100 mg. intramuscularly.

Neurological Examination: The optic atrophy was now more marked on the left side and the visual acuity was 20/200 O.S. and 20/100 O.D. Upward gaze was impaired but other extraocular movements were normal. The left corneal reflex was decreased and there was a left lower facial weakness. The tongue was deviated to the left on protrusion. The left hand grip and flexion of the left elbow were weak. The left knee jerk was brisk, but other tendon reflexes were normal. The left plantar response was extensor and the right was flexor. Sensation was normal.

Laboratory Data: The lumbar puncture showed normal opening and closing pressures and the spinal fluid contained 72 lymphocytes and 11 polymorphonuclear cells. The protein content was 26 mg. percent. The sedimentation rate was 36 millimeters in the first hour (Westergreen). Serum electrophoresis showed an elevation of the alpha II globulin. An electroencephalogram showed a background of 4 to 5 per second high to moderate voltage theta activity, with occasional occipito-temporal spikes bilaterally. Routine laboratory investigations and a lumbar pneumoencephalogram were normal. During this admission, he complained of recurrent frontal and temporal headaches with nausea and vomiting and developed acute retention of urine. A cystometrogram showed impairment of bladder sensation.

Treatment: He was treated with sodium diphenylhydantoin (Dilantin) 50 mg. four times a day, bethanechol chloride (Urecholine Chloride) 5 mg. three times daily, and methyl prednisolone (Medrol) 60 mg. every other day. He again showed a rapid improvement and was discharged four weeks later on sodium diphenylhydantoin, 50 mg. four times daily. The steroids were gradually withdrawn.

The next admission was two weeks later when he became blind and ataxic and had a focal left-sided seizure and vomiting. He was stuporous and the optic atrophy was more marked. There was a left hemiplegia. Treatment was begun with Primidone, 125 mg. every night at bedtime, and 40 mg. Methyl Prednisolone every other day and he again responded. An electroretinogram by Dr. A. Ruedemann, Jr., was compatible with optic nerve degeneration. The Methyl Prednisolone was slowly reduced over the next 4 weeks but when it was reduced to 8 mg. every other day he began vomiting, his eyesight deteriorated, he became irritable, ataxic and unable to walk without assistance. He was again admitted to the hospital where neurological examination showed signs indicating diffuse cerebral, cerebellar and spinal cord disease. The EEG was now diffusely abnormal. The cerebrospinal fluid contained 72 lymphocytes and 11 polymorphonuclear leukocytes with a total protein content of 129 mg%.

Methyl Prednisolone, 60 mg. every other day, was reinstituted and he again improved. During subsequent follow-up visits, the dosage of Methyl Prednisolone was reduced gradually every six weeks by 8 mg. every other day, but was maintained at 16 mg. every other day for 12 months and then was discontinued.

The fifth admission was on May 8, 1966, due to status epilepticus lasting about 36 hours. On general physical examination, the temperature was 99 degrees Fahrenheit, the pulse was 136 beats per minute and the blood pressure was 100/70 mm. hg. There was slight neck stiffness and the throat was inflamed.

Neurological Examination: The patient remained drowsy for forty-eight hours after re-institution of steroid therapy in the form of Prednisone* and was aphasic for a week. Thereafter there was a gradual return of speech during the second week. There was bilateral optic atrophy. The deep tendon reflexes were normal except for absence of the ankle jerks. Both plantar responses were flexor. The sensation was normal. Coordination testing showed poor coordination and dysmetria. Gait was broad-based and ataxic.

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*Prednisone was kindly supplied in the form of Meticorten by the Schering Corporation.

Laboratory Data: On lumbar puncture, the opening and closing pressures were normal, but the spinal fluid showed 300 red blood cells, 8 lymphocytes and 24 polymorphonuclears. The protein content was 26 mg. percent, the glucose content 60 mg. percent and chloride content 26 meq/liter. The total white blood cell count was 23,000 per cu.mm. with polymorphonuclears 70%, bands 19% and lymphocytes 11%. An electroencephalogram showed diffuse high and medium voltage delta waves which were more marked over the left hemisphere and maximal over the left frontal and temporal regions. Subsequent electroencephalograms showed improvement with symmetrical moderate voltage delta and theta activity over both hemispheres. Urine analysis and repeated urine cultures were negative. The serum calcium and phosphorus content, alkaline phosphatase levels and serum protein electrophoresis were normal. The blood urea nitrogen and a two-hour postprandial blood sugar were normal, as were the serum electrolytes. Repeated blood counts, roentgenogram of the chest, tomography of the optic foramina and a radio active mercury brain scan were all normal. Repeated tests for metachromatic bodies in the urine were negative and the urinary amino acid levels were all normal. A small brain biopsy of cerebral cortex obtained from the right parietal lobe was reported to be within normal limits without evidence of neuronal inclusion bodies.

Treatment: Prednisone therapy, 80 mg. every other day, was reinstituted. He was treated with sodium amobarbital, 250 mg. intravenously, and sodium diphenylhydantoin, 100 mg. intramuscularly, for status epilepticus and his seizures ceased. He was then treated with sodium diphenylhydantoin, 50 mg. four times daily and primidone, 125 mg. twice daily. He was discharged one month later on sodium diphenylhydantoin, 50 mg. four times daily, primidone, 125 mg. twice daily and Prednisone, 60 mg. every other day. At the time of discharge, he was able to speak a complete sentence and was oriented to time, place and person. He had a mild ataxia but his gait had greatly improved.

Since discharge he has remained free from seizures, but both anticonvulsant and corticosteroid therapy have been continued. He has been maintained on Prednisone (Meticorten) 50 mg. every other day. There appears to be a mild degree of persisting intellectual impairment and optic atrophy. Other than this, his neurological examination is within normal limits and his vision is good despite the pallor of the optic discs.

Clinical Diagnosis: This boy has now suffered five attacks of acute neurological disorder, in each attack there has been evidence of diffuse involvement of the central nervous system. The signs have included blindness with optic atrophy, recurrent hemiparesis, epliptic seizures, aphasia and ataxia. Each attack appears to result in improvement of the neurological signs and maintenance therapy with 50 mgs. of prednisone every other day appears to have prevented further attacks.

Discussion

Primary demyelinating diseases of the central nervous system may be classified into three groups:

Group 1 The lipidosis and dysmyelinating diseases associated with storage of abnormal metabolic products. This group includes the classical lipidoses, such as Tay-Sachs disease.

Group 2 The familial leukodystrophies, including spongy degeneration of the central nervous system; sudanophilic leukodystrophy; globoid cell (Krabbe) leukodystrophy; leukodystrophy with diffuse Rosenthal Fiber Formation; Pelizaeus-Merzbacher disease; and Metachromatic leukodystrophy.

Group 3 The primary demyelinating diseases.

a) Schilder's disease.

b) Balo's disease.

c) Multiple sclerosis.

d) Neuromyelitis optica (Devic's disease)

e) Post and parainfectious leukoencephalitis.

f) Post vaccination leukoencephalitis.

g) Acute hemorrhagic leukoencephalopathy.

This paper is concerned with treatment of the demyelinating diseases classified here as Group 3 a) and e), namely Schilder's disease and post and parainfectious leukoencephalitis. Acute demyelinating diseases such as post-infectious leukoencephalitis, multiple sclerosis and Schilder's disease may show some spontaneous remissions which makes the interpretation of the effects of any treatment a difficult procedure. In the series of cases reported here, rapid improvement followed the use of steroids in each case and was so striking that it appeared to us that the treatment must have influenced the course of the disease. This impression was strikingly reinforced by the repeated and prompt response to steroid therapy shown in a whole series of acute exacerbations in the child with Schilder's disease and the cessation of further exacerbations with maintenance therapy for more than one year.

Almost all the reports in the literature have been concerned with the use of ACTH in the treatment of demyelinating diseases but whether the treatment was with ACTH or cortisol and its derivatives, side effects such as Cushing's syndrome with the continuous use of large doses imposed a serious limitation on the duration of treatment. This was the reason that we were hesitant at first to use maintenance dosage in the case with Schilder's disease. Fortunately the majority, if not all the side effects, can be abolished by the intermittent use of steroids. The intermittent program of therapy is based on the observation that the therapeutic effects of steroids appear to persist longer than the metabolic effects.[7] Intermittent dosage given every other day allows metabolic equilibrium to be restored between doses and minimizes or abolishes the harmful metabolic effects of large dosage while the anti-inflammatory effect is continued.

In practice, it has been found that a single dose of Methyl Prednisolone or Prednisone every other day is effective in the treatment of demyelinating diseases with little evidence of side effects. This has been particularly apparent in the case of Schilder's disease who is still being treated every other day with high dosage of steroids and has no signs of Cushing's disease.

While this form of intermittent steroid therapy is ideally suited for conditions requiring long-term treatment, we have found it equally effective in the short-term treatment of post-infectious leukoencephalitis where only a short period of treatment may be required, as in the three patients reported here.

The results of this study have indicated to us that if steroid therapy is used in the treatment of the acute exacerbation of multiple sclerosis, (a disease rarely affecting children but unfortunately a common problem in adult neurological practice) intermittent therapy should be used. This has now become the standard procedure in the Neurology Department at Harper Hospital. An additional benefit of this form of therapy is that it is less likely to cause adrenal cortical suppression even when given over a period of many months and symptoms of adrenal insufficiency are not seen during withdrawal of the drug.

Summary

Evidence that ACTH and corticosteroids are effective in the treatment of the demyelinating processes are cited both in experimental allergic encephalomylitis and in certain demyelinating diseases occurring in adults such as multiple sclerosis. Treatment has been limited by the development of serious side effects, such as Cushing's syndrome. Four cases are reported as evidence that corticosteroid therapy is effective in the treatment of post-infectious leukoencephalitis and in Schilder's disease.

The administration of methyl prednisolone (Medrol) or prednisone (Meticorten) in a single oral dose once every 48 hours permits adequate anti-inflammatory effects with restoration of metabolic equilibrium between doses and the reduction of side effects even with the long-term use of high doses. This form of therapy is recommended for the treatment of demyelinating diseases and

should be considered when long-term steroid therapy is indicated. ☐

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Where does MSMS stand on matters of communications and public relations?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS.

The November issue of *Michigan Medicine*, on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Various chapters of the book are being printed each month for all MSMS members to study. This month, Chapter Seven is printed in full.

Discussion

Medical Public Relations

MSMS had the earliest statewide, planned public relations program of any state medical association. It set many patterns of communication and public relations practice which have stood the profession in good stead over the years.

PR Plans

On the other hand, money for PR purposes has been progressively cut back over the last ten years, and plans have often remained just plans in Michigan whereas in other states these same plans supplied by Michigan have been adopted and implemented to the advantage of medicine.

Michigan Health Council

Michigan Association of the Professions

Much of the medical public relations and communication program of MSMS is now being fostered and financed by others. Of particular importance in this area are MAP and the Michigan Health Council. If their respective services were to be lost or diminished, the MSMS public relations program would be lost or diminished in direct proportion, although not to the same degree, because fine contributions are being made by MSMS membership and staff in the work of MAP and MHC.

Publicity Liaison

Also, outstanding efforts are succeeding in the respective fields of publicity and liaison with both communication media and opinion-molding groups and persons. Both have been perfected and followed through upon in Michigan better, perhaps, than anywhere else in the nation on either a local, state, or national level.

Communication with Membership

Overlooked in most public relations programs is the necessity of communicating with the association membership. This is one area which has been emphasized in the past few years in Michigan. Although the system is still not mature, it is being pointed to as exemplary by others and daily receives the accolade of imitation.

Financing

Many suggestions for improvement in communications with the public are inherent in the questions which follow. The main problem is not ideas or know-how but funds.

Ideas for communication with membership must overcome the competition of other printed media for the time the doctor has to read . . . or to use other media sufficiently intriguing to gain his attention and time.

Questions

MICHIGAN MEDICINE Weekly?

A. Would there be any advantages over the present journal of a weekly publication of MICHIGAN MEDICINE, but carrying no scientific papers, combined with a quarterly carrying a large collection of original scientific papers? This weekly publication would carry all organization news, legislation, meeting notices and reviews, news of governmental rule changes, special TV programs, etc., etc.

Continuous Physician Opinion Survey

B. Should a random sampling survey system be developed which could be used economically and at semi-monthly intervals to provide a continuing study of

1. Medical opinion of AMA and MSMS projects?
2. Physicians' reactions to local, state, and national events of health or professional importance?
3. A pretest of a variety of policies and plans of organized medicine?

Two-way Radio Network

C. Would a two-way radio network among the individual members and the MSMS headquarters and the component medical society headquarters be feasible? Such a network might supply music for doctors' offices, news scientific papers, etc. How can it be financed?

Public Speaking Classes

D. Would a course in public speaking on a three-session-per-year basis be patronized by MSMS and aid them in lecturing on MSMS policies and professional objectives?

Video Tape Recording

E. How efficacious would be a video tape system (tapes made nationally, state, and locally with statewide distribution and a headquarters library) in serving the purpose of communicating medical society programs and policies as well as scientific information?

Regional State Society Meetings

F. How valuable for communication purposes are meetings held around the state on a planned basis between officers of the MSMS and groups of CMS leaders? Should they be continued?

Handbook for Officers

G. Would an "MSMS Handbook for CMS Officers" be a valuable aid in communicating medical policy between state and component societies?

Liaison with Communication Media

H. How can closer liaison at the community level be established and maintained between organized medicine and newspapers? Radio? TV? Should the MSMS sponsor regional meetings between doctors and these media as was done some years ago? ☐

Let's be specific about Campbell's Soups... and *reducing diets*

Calorie content of Campbell's Soups

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

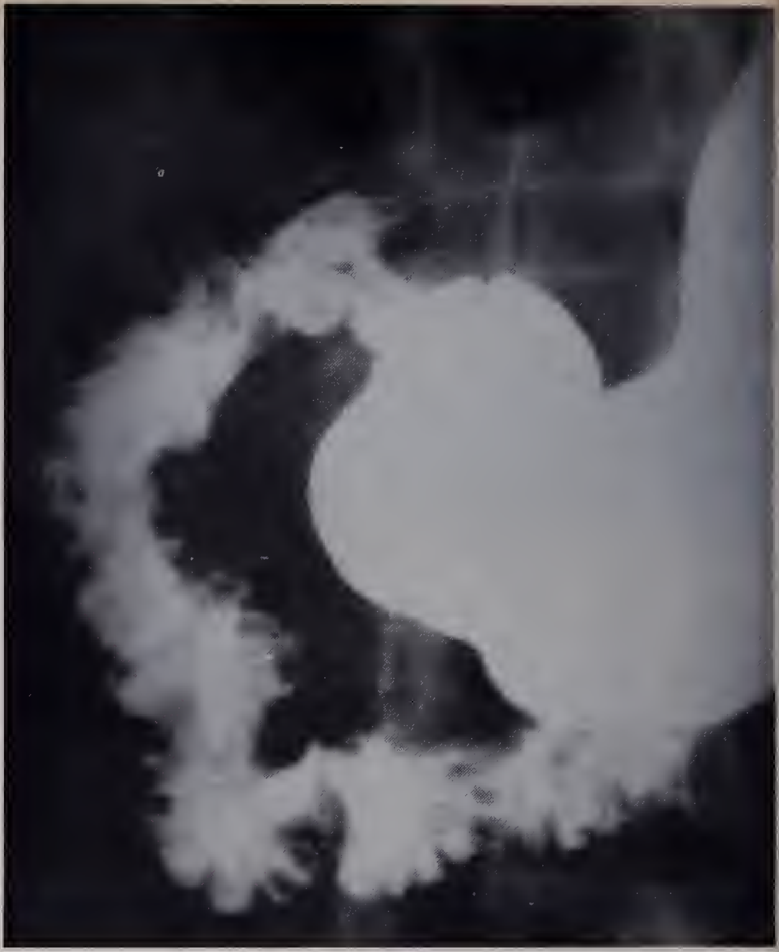
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N.J. 08101

Campbell's
CONDENSED
SOUP

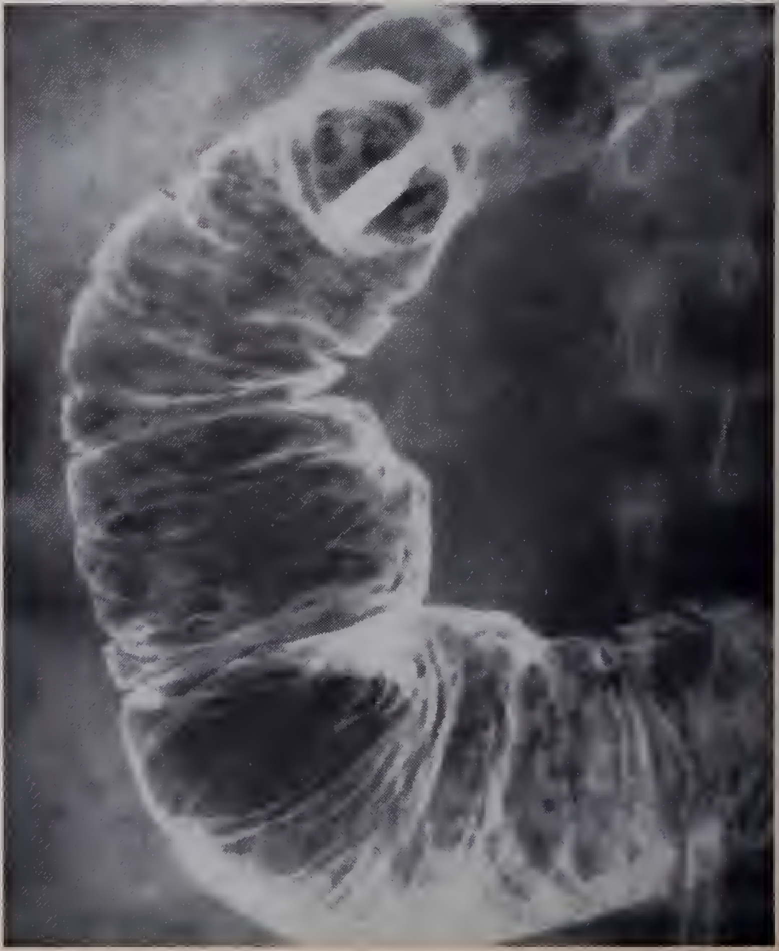
Conventional Radiography

The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?



Hypotonic Duodenography

Pro-Banthīne-induced duodenal calm permits full anatomic appraisal: Same patient. Duodenal normality is now evident.



- **in diagnosis**
- **in treatment**

Pro-Banthīne® brand of propantheline bromide

calms the gastrointestinal tract

For fifteen years Pro-Banthīne has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthīne has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthīne. The duodenum was intubated. Pro-Banthīne in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

SEARLE

Research in the Service of Medicine

"Breathing's a snap again," he said gingerly.
(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

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in sinusitis, colds, U.R.I.

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(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

SAMA TO HEAR ANN LANDERS

Problem-solver Ann Landers, whose husband is a Chicago physician, will speak on "The Young Doctor's Wife," on Friday, April 26 at the Student American Medical Association meeting.

The WSU SAMA will host the national convention, April 24-28.

PG Committee Adds Howell

A program at Howell for the Livingston County Medical Society will be a new offering this spring by the MSMS Committee on Postgraduate Medical Education.

A total of 20 programs will be presented this spring in Michigan by the MSMS Committee in cooperation with the three Michigan medical schools and the State Department of Public Health.

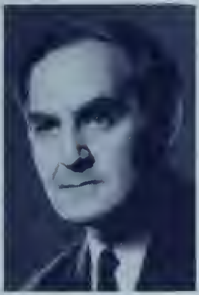
Following is a list of the communities which will host the programs, many of which will include a clinical demonstration and discussion:

Upper Peninsula

Houghton—Monday, May 13
Sault Ste. Marie—Monday, May 13
Manistique—Tuesday, May 14
Escanaba—Tuesday, May 14
Ironwood—Tuesday, May 14
Iron Mountain—Wednesday, May 15
Menominee—Wednesday, May 15
Marquette—Thursday, May 16

Lower Peninsula

Alpena—Thursday, April 18
Battle Creek—Tuesday, May 7
Cadillac—Thursday, May 23
Grayling—Thursday, April 25
Lansing—Date to be set
Howell—Tuesday, May 7
Midland—Thursday, May 9
Muskegon—Wednesday, May 15
Niles—Tuesday, May 21
Holland—Friday, May 3
Petoskey—Thursday, April 11



'68 Annual Session Cut To 2 Days, Sept. 25-26

Under the chairmanship of Alexander J. Walt, M.D., the 1968 Annual Session Planning Committee has developed the basic programs for the September meeting. To be held Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, the Annual Session will involve two days of courses, general meetings, and section meetings.

The program, as currently developed, is as follows:

WEDNESDAY, SEPTEMBER 25

1) Section meetings: To be held throughout the day.

2) General meetings: The morning will be devoted to Problems of the Foetus and Breast Carcinoma. The afternoon will focus on Trauma, Pediatric Problems, and Relief of Pain.

3) Courses: To be held throughout the day on Infectious Diseases and Pulmonary Diseases.

At 8:00 p.m. the Annual State Society Dinner Dance will be held.

THURSDAY, SEPTEMBER 26

1) Section meetings: To be held throughout the day.

2) General meetings: The morning will be devoted to Cardiovascular Diseases and Prostate Carcinoma and Calcium. The afternoon will focus on Psychoanalytic Problems of the Aging Population and on What's New? For example, in the field of Transplantation, Cancer, Thyroid, Urology, Gynecology, Infectious Diseases, Shock, G-I Tract Diseases, Pediatrics.

3) Courses: To be held throughout the day on G-I Tract Diseases and Blood Diseases.

Members of the Annual Session Planning Committee are: Alexander J. Walt, M.D., chairman of the surgery department at Wayne State University Medical School, Chairman; T. A. Baker, M.D., West Branch; W. C. Baum, M.D., Grand Rapids; K. H. Johnson, M.D., Lansing; H. A. Towsley, M.D., and N. A. Vanselow, M.D., both of Ann Arbor; A. M. Lerner, M.D., F. P. Rhoades, M.D., Geoffrey L. Brinkman, M.D., R. F. Wilson, M.D., F B Bicknell, M.D., T. N. Evans, M.D., and W. S. Haubrich, M.D., all of Detroit.

The recommendation of the Planning Committee that the 1968 Annual Session be limited to two full days, rather than ending on Friday with a half-day program, was approved by The MSMS Council at its March meeting.

SPECIAL PROCEEDINGS FOLLOW BLUE PAGES —

MSMS members may wish to pull out the four cream-colored pages immediately after the blue breaking-news pages in the middle of this issue. Members may want to read and file the official actions of the recent special meeting of the MSMS House of Delegates.

Pages may be removed easily now from the perfect-binding method used by *Michigan Medicine.*

Three Groups Elect Officers

Edwin DeJongh, M.D., clinical assistant professor of occupational medicine at Wayne State University, has been elected president of the American Academy of Occupational Medicine. Doctor DeJongh, who has served two terms on the board of directors of Industrial Medical Association, is now a member of the rehabilitation and screening committees of the Michigan Heart Association, a trustee of the Greater Detroit Council of Alcoholism and the Detroit Rehabilitation Center, and guest lecturer in the Institute of Industrial Health at the University of Michigan.

* * *

The Kent Medical Foundation at its annual meeting re-elected Fred C. Brace, M.D., president, and Charles A. Wilkinson, M.D., secretary-treasurer, for the coming year. Harold Bowman, M.D., and John R. Wilson, M.D., were elected to three-year terms on the board of trustees. The foundation seeks to promote careers in health fields through scholarships, loans and tuition grants.

* * *

The new officers of the Detroit Industrial Physicians Club were installed at a recent meeting. The new president is E. A. Shaptini, M.D.; president-elect, D. C. Laderach, M.D.; Secretary-Treasurer, M. S. Lechner, M.D.; and Member-at-Large, P. L. Neiswander, M.D.

TO DRAFT ALIENS

A check is being made to determine how many alien physicians, dentists and "allied specialists" are now subject to draft laws. A new law for the first time makes aliens in the medical and dental professions subject to draft up to age 35.

Slagle Keynotes Socio-Econ Congress

Three Michigan physicians spoke at the 2nd National Congress on the Socio-Economics of Health Care in Chicago, March 22-23. George W. Slagle, M.D., Battle Creek, was chairman of the Congress.

Doctor Slagle, also chairman of the AMA Council on Medical Service, opened the two-day meeting outlining "Goals of the Congress." James T. Howell, M.D., executive director of the Henry Ford Hospital, Detroit, addressed the group on "Group Practice in Action — Its Effect on Quality of Care," and Vergil N. Slee, M.D., Ann Arbor, director of the Commission on Professional and Hospital Activities, spoke about "The Physician as an Evaluator of Care."

Doctors Help Plan Hospital Conference

Three physicians are serving on the planning committee for the 1968 Medical Staff-Trustee-Administrator Forum to be held May 8 through May 11 at the Boyne Mountain Lodge. Julien Priver, M.D., executive vice-president of Sinai Hospital of Detroit, is chairman of the planning committee. William H. Meade, M.D., Lansing, and Roger B. Nelson, M.D., Ann Arbor, are also members of the committee.

The meeting is being sponsored jointly by the Michigan Hospital Association, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons, and Michigan Osteopathic Hospital Association to develop better communications between hospital medical staffs, trustees, and administrators.

SOCIAL SECURITY EXPERIMENTS WITH PAYMENT PLANS

Social Security Commissioner Robert M. Ball, following President Johnson's Health Message recently announced an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy.

The medicaid and maternal and child health programs, as well as the medicare program, will be involved in some of the experiments, the Commissioner said.

Participation, which is entirely voluntary, will be welcomed from hospitals, physicians, and health care organizations and institutions. A panel of experts will evaluate and select proposals for experimentation.

Experiments which turn out favorably, Commissioner Ball said, may benefit the entire health care system, private as well as governmental. The present system of reimbursement under medicare may be waived for the experimental projects, he said.

Hypertension, Topic At Lansing, May 23

A "Spring Hypertension Symposium" will be held at E. W. Sparrow Hospital, Lansing, Thursday, May 23, co-sponsored by E. W. Sparrow Hospital, the Ingham County Medical Society and MSU College of Human Medicine.

Speakers will include Ralph Straffon, M.D., Cleveland Clinic; Edward D. Freis, M.D., Washington, D.C.; A. A. Hodari, M.D., Henry Ford Hospital; S. W. Hoobler, M.D., University of Michigan and F. J. Haddy, M.D., Michigan State University. The morning and afternoon discussion seminars will be followed by a dinner at the Elks Club with "Duffy" Daugherty as the speaker.

Extract of March Council Meeting

Following are some highlights of the March 6 meeting of The MSMS Council:

Guest of The Council at luncheon was the new Director of the Michigan Department of Mental Health, William Anderson, M.D.

The Council nominated for the two vacancies on the Michigan Hospital Service Board of Trustees incumbent Wm. S. Reveno, M.D., incumbent Herbert W. Harris, M.D., and A. Carl Stander, M.D.

Appointed to the Medical Advisory Committee of the Blue Shield Utilization Review Project was D. F. Sarapo, M.D., of Adrian.

FOLLOWING THE approval, by the Special Session of the House of Delegates, of the new MSMS Asset Management Plan, The Council adopted a set of basic procedures and appointed a 5-man Board of Managers: Treasurer John R. Ylvisaker, M.D.; Finance Chairman Robert K. Whiteley, M.D.; C. Allen Payne, M.D.; Ross V. Taylor, M.D.; and Mr. Thomas Wagner. Executive staff assistant will be Warren F. Tryloff.

Upon the invitation of the Michigan Arthritis Foundation MSMS will co-sponsor a two-day Conference on Arthritis, May 11-12, Detroit.

Fifty copies of *Michigan Medicine* will be presented at no cost to senior medical students at each medical school in Michigan.

The Council recommended that the adjudication appeal mechanisms available to Michigan Medical Service be made available to other insurance carriers through existing adjudication mechanisms.

THE COUNCIL approved a recommendation of the Public Health Committee that, because MSMS wishes to aid in protecting the public and physicians from the hazards of defective radiation equipment, it recommends that in problem cases the chief of the MDPH Radiation Section consult with the Public Health Committee's advisors on radiation, who in turn can contact the physician in person or notify the component medical society of the violation. If, after contact is made, the physician still fails to comply, the Chief will contact a law enforcement agency.

EXCITING
CAREERS IN HEALTH

The Health Careers Mobile, now telling Detroit students about the need for more doctors and health associates, has a new Wayne State University Medical School exhibit. The fine photos are discussed by Robert K. Whiteley, M.D., MSMS Councilor from Detroit; and MSMS President-Elect James J. Lightbody, M.D., Detroit.

The Council approved a recommendation of the Committee on Governmental Medical Care Programs that The Council should acquaint every member and every component medical society with the extreme necessity and importance of every physician becoming actively involved with all possible private and public health organizations concerned with every aspect of health and related fields at all local and state levels. Further, The Council should communicate with all component societies urging each to strongly suggest to their entire membership that, when health planning and similar organizations request them to serve, they ask the organization to channel the request through the component medical society and themselves notify their component medical society that they have been approached. Further, The Council communication should also urge every component medical society to contact all health planning and similar organizations in its area and offer to cooperate in the selection of appropriate medical members for their board and committees, and should maintain an accurate roster of all members serving in such capacities.

THE RESOLUTION of the Maternal Health Committee re Teaching of Family Life and Sex Education in Michigan Public Schools was approved. The full text of the resolution will appear in next month's *Michigan Medicine*.

Upon recommendation of the Committee on Maternal Health, The Council will urge the Department of Public Health to continue and improve comparative studies of perinatal mortality and morbidity in hospitals.

The Council authorized an outstanding health service award to the Michigan Congress of Parents and Teachers (PTA).

HEALTH PLANNING EXECUTIVE NAMED

Mrs. Betty Tableman has been named by Governor Romney to be executive director of the Comprehensive State Health Planning Commission (PL 89-749).

Appointed last August, the five-member Commission will oversee Comprehensive Health Planning in Michigan under recent federal legislation. Chairman of the Commission is R. G. Rice, M.D., Acting Director of the State Department of Public Health. Charles Orlebeke, an executive assistant in the Executive Office, is vice-chairman. Other Commission members include William H. Anderson, M.D., State Mental Health Director; R. Bernard Houston, State Social Services Director, and Glenn S. Allen, Jr., State Budget Director.

Mrs. Tableman was on the staff of the State Public Health Department for several years in planning activities.

AMA PAMPHLET TELLS REASONS FOR BELONGING

Why should I belong to the AMA?

A hundred or more clear-cut reasons are given in a new eight-page pamphlet entitled, "Make the Most of Your American Medical Association."

Suggested for distribution to prospective new members and others, the pamphlet highlights major services and materials available from the AMA, lists reference books, enumerates services and publications available on practice management, physician-patient relations and community service.

Medical societies may obtain review copies or quantity copies by writing the Program Services Department. Single copies are also available from the AMA, 535 N. Dearborn, Chicago, for members or prospective members.

GPs Complete Annual Clinic

The 22nd Annual Postgraduate Clinic sponsored by the Michigan Academy of General Practice at the Sheraton-Cadillac Hotel in Detroit, March 13-14, drew an estimated 700 physicians.

"The clinic went very well," commented Francis P. Rhoades, M.D., director of the scientific assembly committee. "We had 24 speakers from all over the United States, covering a wide variety of subjects. Also we had 32 outstanding scientific exhibits."

Six MDPAC, MSMS Leaders Participate In AMPAC School

Attending a two-day AMPAC National Workshop, March 9-10, in Washington, D.C., were MDPAC Leaders Vernon V. Bass, M.D., Saginaw; Donato F. Sarapo, M.D., Adrian; Edgar J. Geist, Jr., M.D., Rochester; John R. Franck, Jr., M.D., Wakefield; James J. Lightbody, M.D., Detroit; Frederick Van Duyne, M.D., Flint, and Ralph T. Wills, of the MSMS staff.

Leading off the program was Ernest B. Howard, M.D., AMA Assistant Executive Vice President, who outlined the challenge which medicine faces and the contribution which the PAC movement can make.

"As a citizen responsible to his nation, the PAC physician is called upon to seek good government through the political process of electing good men," he said. "That adds to his load. But if he will shoulder both burdens manfully, we have it within our capacity to preserve an unrivalled system of health care and an unmatched heritage of freedom."

NEWS; AND ITS BRIEF

Matthew S. Hurth, M.D., Lansing, received the B'nai B'rith Human Relations Award at the 10th Annual Brotherhood Banquet, co-sponsored by the Community Services Council and B'nai B'rith.

Doctor Hurth, who has contributed his services as athletic physician to Gabriels and Resurrection high schools for many years, was honored for constantly placing "service to mankind above money."

A special award was given to Lieutenant Governor William Milliken for his efforts in the Ingham County Family-to-Family Volunteer Services project.

After a brief suspension caused by Viet Cong attacks on the cities, the AMA Volunteer Physicians for Vietnam Program is back in operation.

* * *

President Johnson asked Congress for $571.7 million more for medicaid for the 1968 fiscal year ending July 1, 1968.

The administration said the initial appropriation proved inadequate because of a complete lack of data and experience as to costs of such a program and a larger increase than expected in costs of hospital and other medical care.

Michigan State Medical Society
Special Session of the House of Delegates
February 14, 1968

1. Call to Order

A Special Session of the 1967 House of Delegates of the Michigan State Medical Society convened at 1:55 p.m. in the Auditorium of the Wayne County Medical Society, 1010 Antietam Road, Detroit, Michigan, with James B. Blodgett, MD, Speaker of the House, presiding.

2. Report of Credentials Committee

Chairman K. T. McGunegle, MD, reported, "There are 111 delegates seated. A majority are not from any one county."

3. Speaker's Remarks — James B. Blodgett, MD

The Speaker reviewed the purpose of the Special Session, called by the Speaker, at the request of The Council, to consider a proposed new asset management plan for the Michigan State Medical Society.

Assisting the Speaker were MSMS Legal Counsel A. Stewart Kerr; Parliamentarian Charles King, Dean, Detroit College of Law; Secretary Kenneth H. Johnson, MD; and Vice-Speaker Vernon V. Bass, MD.

4. Vice-Speaker's Remarks — Vernon V. Bass, MD

At the request of the Speaker, Doctor Bass reviewed the actions of the 1967 House of Delegates on the Ways and Means Reference Committee report, as follows:

"The Reference Committee on Ways and Means, S. N. Kelso, Jr., MD, Chairman, reported as follows:

"This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS. However, because of the newer concept of financing proposed, the Reference Committee feels that the members of the House of Delegates should have more time to better acquaint themselves with the proposed changes.

"Your Reference Committee recommends that a committee of the House of Delegates be appointed to further consider this proposal and further acquaint the county medical societies with the intent and implications of this proposal, the committee to be instructed to report back to the 1968 House of Delegates.

"The House amended the report so that it read: 'This Reference Committee approves in principle the recommendations of the Treasurer's Report and also the recommendations of the Committee to Study the Financial Structure of MSMS.' The House then adopted the report as amended."

5. Council Chairman's Remarks — Robert J. Mason, MD

The delegates today will consider a plan for revising the management of the State Society assets. A review of these events leading to this consideration may be helpful in your deliberations.

The MSMS Treasurer in 1966 undertook a review of the Society's investments, financing and reserve policies and informed The Council and its Finance Committee that he believed some modernization of our practice was in order. He was authorized to proceed in the development of specific recommendations for change. At various stages of refinement, these recommendations were presented to The Council as information. The plan in final form was presented to The Council's Finance Committee in July of 1967. The Finance Committee approved the plan after minor amendments, and its transmittal to the 1967 House of Delegates was authorized.

You may recall that this House approved "in principle" the plan for revision of asset management. The precise intent of the House was obscure to The Council which was responsible for the implementation of House instructions. The Council, therefore, authorized the Treasurer to refine the new asset management plan and to obtain written, specific commitments from the various parties involved, so that the specific and detailed final proposal implementation could be reviewed.

The details of the final plan were presented to The Council in November, 1967, studied for a month, approved by The Council at its December meeting and recommended to the House of Delegates for its approval at a special session.

While The Council favors the plan, it believed that the House must authorize its implementation.

In making the decision to call the House into special session, The Council considered all aspects of the situation.

First, before the asset management plan could be seriously studied, it was necessary for The Council and its Finance Committee to know just what terms, conditions and rate of interest could be obtained. This was done in writing as a specific bank commitment in November. It would be honored for a reasonable length of time, but not until next September when the House could consider it in regular session.

Because of this, and because of the fact that the interest rates were so favorable in a rising money market, The Council called a special session of the House to authorize implementation of the asset management plan.

The House then meets today in special session to consider this recommendation of The Council, and I quote:

"That the House of Delegates approve the plan for revising the management of MSMS assets, and authorize The Council to implement the plan in accordance with the By-laws as amended at this House."

And Mr. Speaker, with your permission, sir, I would like now to ask our Treasurer, Dr. John R. Ylvisaker, to address this august delegation and to highlight the details of the asset management proposal.

6. Treasurer's Report — John R. Ylvisaker, MD

Gentlemen, I have addressed you previously as a body and many of you individually or in groups. I have discussed with you the thought processes by which I formulated the financial program now recommended for adoption by MSMS. You have already been presented with the written transcript of my previous address and with two detailed reports which incorporate the essentials of the program, the financial data demonstrating the need of a responsible fiscal policy and the steps by which this program could satisfy such a need within the Society budget and out of the Society's present resources. You have studied this information, I am sure, and it requires no repetition.

It will be subject to questioning later, if you wish.

The proposed program is formulated to accomplish objectives which are essential to sound business administration and to the furtherance of the stated purpose for which the Society exists, namely:

1. The promotion of the science and art of medicine,

2. The protection of the public health, and

3. The betterment of the medical profession.

The objectives of the asset management plan are:

1. The retirement of current expenses out of current income (a positive rather than a negative cash flow position).

2. The proper management of debt both by securing such debt for the lender and by amortizing the amount within the Society budget with a progressive scheduled long-term retirement based on membership participation in the benefits which the debt has purchased for the Society.

3. The provision of funded reserves adequate to protect the Society against demands caused by recurring predictable capital needs as well as unpredictable contingency needs.

4. The establishment and initial funding of a service reserve or trust, the income and growth of which may provide resources for a positive service program consonant with the purposes and responsibilities of the Society.

5. The proper management of money derived from membership dues:

a. to provide fixed-dollar amounts sufficient to meet fixed-dollar needs;

b. to protect the purchasing power of dollars designated as long term reserves;

c. to achieve maximum income, stability and growth, where possible, to protect the membership against unwarranted additional cash demands either as dues or assessments.

The proposed program embodies all of the above. It acknowledges the debt of the Society and assigns this debt to its rightful position as a mortgage on the headquarters building. It mobilizes a dollar appreciation of the headquarters building, leaving intact a substantial equity position. It transfers this appreciation to essential fund categories to stabilize and further the function of the Society. It provides for debt retirement within the capabilities of the Society budget. It spreads this debt over the useful life of the building and apportions its cost progressively to succeeding current memberships.

However, this program has a recognized cost measured by the possible difference between the interest paid on borrowed money and the income/growth received from invested money. The program cannot and will not avert dues increase or assessments if increase in future operation should place such demand on the Society. Also, a portion of the funds would be subject to fluctuations of the general economy in times of recession as well as "boom," but would nevertheless retain value relative to the economy.

I should like to address myself to two recurring questions:

1. Does this program represent sound business practice?

2. Is it morally correct for the Society to invest monies derived from membership dues in income or growth producing investment vehicles?

At the request of The Council, written opinions concerning tax consequences and business policy were obtained from consultants retained by MSMS. The conclusion of the research by the Alexander Grant Company, a national accounting and tax consultant firm, was that there is no conflict of this program with present rules and regulations of the IRS. A review by A. Stewart Kerr, Legal Counsel of the firm of Sweeney, Dodd & Kerr, concurred with the conclusions of Alexander Grant and Company with the statement, "In summary, there are no tax objections in the near future to mortgaging and investing in the manner that you have suggested."

Dr. Clyde Hardwick, Professor of Economics, of the University of Detroit, drew the distinction between present asset management as "old economics" and the proposed program as "new economics," indicating that this proposal would "allow MSMS a flexible plan to roll, react, and adjust to the changing general economy." I should like to emphasize that none of the three consultants took a position of advice, of approval, or of disapproval.

My personal position is that the recommended program provides the Society with a considerable increase in financial protection and depth in all areas of responsibility, whether to members, employees, lenders, the public or posterity. It is morally less defensible not to provide adequate financial protection of the Society and its responsibilities than to pursue a philosophy and adopt a policy which dedicates itself to that end.

To satisfy further possible objections, I approached the Regional Office of the IRS, specifically the Division of Tax Exempt Organizations. Initially, I was informed a memorandum of opinion would be supplied. This was later withheld on a judgment basis only. However, the summary of long detailed conversations supported the conclusions of the Alexander Grant Company and Mr. Kerr whose opinions were discussed directly with the IRS officials.

For an independent, objective view of the fiscal policy involved, as well as of the propriety of the Society to engage in such a program including investment in income and growth instruments, I have taken several further steps. One of these was to approach an economist by the name of Dr. Zentz, a PhD who was previously with the Federal Reserve Board and now is Vice President of the Bank of the Commonwealth, and explained what the plan was and how we were preparing to implement this. He wrote me the following letter:

"Dear Dr. Ylvisaker:

"You have asked me what is common practice, and what Bank of the Commonwealth Trust Department recommendations would be concerning the investment of endowment and other longer-term funds of not-for-profit organizations such as the Michigan Medical Society.

"I can say with considerable confidence that common practice, both in this Bank and in the trust departments of major New York banks many times our size, is for such funds to be invested approximately ⅔ in common stock and ⅓ in fixed income securities. I would strongly recommend that, over the long run, new monies of this type be invested even more in stocks than this ratio indicates, and I feel confident that other major trust departments are making similar recommendations.

"The reason for this is quite simple. We recommend that some current income be foregone with the expectation of receiving greater future income. There is no other way to protect against continued further erosion in the purchasing power of the dollar. I believe this to be the only truly conservative way to invest, because it attempts to conserve the buying power of the funds invested. Past experience bears this out – not excluding 1929. Even if that year were picked as the time of investment, the investor would be considerably better off today, in terms of total income and value of a quality portfolio, than if investment had been made wholly in what we used to think of as conservative, gilt-edged debt issues.

"Cordially,
"Bill Zentz
Executive Vice President
Investments"

In addition, I have invited two gentlemen to be with us today for brief statements. I would like, Mr. Speaker, if I may have your permission, to provide the floor to each for a very brief statement as a part of my discussion. (Permission was granted.)

Both of these gentlemen are new acquaintances. They express their own opinions. I don't know what they are going to say. I have reviewed the program with them. I have indicated to them the areas in which I would hope they might make some remarks, and they are strictly on their own.

The first gentleman is Dr. Thomas Gies, who is Professor of Finance of the Graduate School of Business Administration of the University of Michigan. Dr. Gies.

Dr. Thomas Gies: It strikes me that very possibly what we are dealing with is the problem of the future, and how you people in conducting the affairs of your association should provide for its future, and you know this provides very considerable authority problems for all kinds of people who deal with this sort of issue.

The future has some surprises for all of us, I am sure, not least of all this Society. How do you responsibly provide for things that you cannot predict? The problem has two dimensions. The first is meeting your routine financial requirements. Things that you can pretty much guess are going to occur in 1968, in 1969 and 1970. These are ongoing sorts of expenses. Secondly, there are going to be some unpredictable expenses that will occur. They are events which you can't predict for yourselves, but which you must prepare for. Then there is another dimension, the matter of developing new types of services and new activities. This is not only in the form of events which impose themselves upon you and which you must meet, but rather these represent opportunities which you can take advantage of if you have funds.

How do you take care of these two or three kinds of problems? In the name of prudent management, it seems to me that my answer to you has to be if you want to go in a direction of developing a capital fund, it must be made up of a kind of asset which does not shrink in value, but which, in fact, grows in value. I can document this in whatever dimensions you would like to go.

I am not inclined to try to frighten people with a specter of a hyper-inflation in the United States. We are not going to have anything like that, but we are going to have periodic occasions when runs on the order of two percent a year, two and a half percent, three, and in 1968 it may turn out to be three and a half percent. It is that kind of inflation, but that kind of inflation erodes rather seriously the value of fixed income securities over long periods of time, as you who have bought bonds, savings bonds and other types of fixed income securities in the past very well understand.

This suggests to me then that one of your guidelines will be that you would like to acquire ownership of types of assets which are likely to advance at least as rapidly as the economy as a whole. This suggests that your society should be investing in some kind of equity assets. The most likely would be high grade common stocks or high grade common stocks combined with some limited amount of debt securities.

The substance of my urging would be at this point if you are interested in a capital investment program, it seems to me it makes some sense in terms of the long run future of this organization, that it should be one composed fairly heavily of equities securities.

John R. Ylvisaker, MD: Thank you, Dr. Gies. The next gentleman is Mr. John Eschrich, Account Executive, in charge of the Institutional Department of Merrill Lynch, Pierce, Fenner & Smith, Inc.

Mr. John Eschrich: Mr. Speaker, Gentlemen: All I'm going to do this afternoon is present the testimony of an expert witness. Not myself, but Mr. Russell Macklin who heads the Portfolio Department for Merrill Lynch, Pierce, Fenner & Smith in New York gave me the following statement:

"The principle of a funded program such as that proposed by Dr. Ylvisaker, is a common and well accepted practice. Churches, social organizations, welfare organizations and universities among others commonly use it. It is a sound method to program the future."

(The following report from Treasurer Ylvisaker was presented to the Delegates in printed form.)

PROPOSED REVISION OF MSMS ASSET MANAGEMENT*

A Program for Initiation and Implementation

I. Essential elements of proposed revision:

A. Discontinuance of present line-of-credit borrowing for operational expenses.

B. Establishment of three fund categories:

1. **Operational fund** — revolving fund for current expenses.
    - a. Replenished annually by income from dues, advertising, booth sales, interest, etc.
    - b. Partially invested in interest-bearing short-term fixed-dollar securities on month-to-month programmed release.
2. **Capital Reserve fund** — self-perpetuating fund for contingencies and replacement of depreciable fixed assets.
    - a. One-half invested in fixed-dollar interest-bearing securities.
    - b. One-half invested in high-grade negotiable securities providing dividend yield and growth.
    - c. Income and growth reinvested continuously providing reserve funds proportionate to growth of Society and its obligations.
3. **Managed Investment fund** — growth fund for extended service to the Society, to component societies, and to members.
    - a. Investment and re-investment by 5-member Board of Trustees in bona fide investment vehicles for balanced portfolio to provide growth, income and stability.
    - b. Interest, dividends, other income and growth to provide continued growth of the fund and extended service.
4. Initial funding by mortgaging of the MSMS headquarters building with long-term budgeted amortization of resultant mortgage debt.

II. Financial data pertinent to proposed revision:

A. Previous annual debt service data:

Year	Maximum Debt	Interest	Reserves	Dues
1961	$250,000	$5,000	$ 59,300	$ 75
1962	210,000	7,200	61,000	80
1963	160,000	6,100	83,000	80
1964	155,000	2,900	106,000	80
1965	245,000	3,000	110,000	80
1966	225,000	5,600	113,000	90
1967	155,000	4,000	122,000	100

B. Present needs:

1. Operational fund — maximum borrowing projected for operational expenses 1967	$180,000
2. Reserve funds — recommended increase	120,000
3. Managed investment fund for inflationary hedge and increased service	up to 350,000
	$650,000

C. 1967 budget items re MSMS headquarters building and assets

Income		Expenses	
Reserve funds	$7,000	Taxes	$16,000
Operational funds	300	Insurance	2,300
		Interest	4,000
		Equity	45,000
	$7,300		$67,300

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*Revised to include actual, rather than projected, 1967 figures.

D. Effect of mortgage financing on MSMS budget—cost/$100,000/year = $100,000 × 7.92% = $7,920 assuming 25-year mortgage at 6¼% interest.

1. Operational fund — $180,000

Income		Expenses	
Reserve fund	$7,000	Taxes	$16,000
Operational funds	10,000	Insurance	2,300
		Interest & equity	12,256
	$17,000		$30,556

Decrease in debt service
$67,300 — 30,500 = $36,800
Increase in interest income
$17,000 — 7,300 = 9,700
Increase in cash available for budget or reserves Total $46,500

2. Capital Reserve fund — $120,000

Income		Expenses	
Reserve fund	$13,000 + growth	Taxes	$16,000
		Insurance	2,300
Operational fund	10,000	Interest & equity	23,760
	$23,000 + growth		$42,060

Decrease in debt service
$67,300 — 42,000 = $25,300
Increase in income $23,000 — 7,300 = 15,700
Increase in cash available for budget or reserves Total $41,000 + growth on $120,000

3. Managed Investment fund — $350,000

Income		Expenses	
Reserve fund	$13,000 + growth	Taxes	$16,000
		Insurance	2,300
Operational fund	10,000	Interest & Equity	51,400
Managed Investment fund	10,500 + growth		
	$33,500 + growth		$69,700

Increase in income $33,500 — 7,300 = $26,200
Increase in debt service
$69,700 — 67,300 = —2,400
Increase in cash available for budget reserves and service Total $23,800 + growth on $470,000

III. Proposal:

A. Accept Michigan National Bank mortgage

Amount	up to $650,000
Interest	6¼%
Term	25 years
Commitment fee	None
Prepayment penalties	None
Draw privileges	$50,000 or more per draw

B. Borrow (or draw) in sequence according to the following priority:

1. Operational funds $180,000
   a. Completion of borrowing March, 1968.
   b. Council review for authorization to proceed to second step.
2. Capital reserve funds $120,000
   a. Completion of borrowing by July, 1968.
   b. Second Council review for authorization to proceed to third step.
3. Managed investment fund up to $350,000
   a. Borrowing period July, 1968 to July, 1969.
   b. Monthly Council review.
   c. Council authorization for each $100,000 of borrowing.
4. Establishment of 5-member Board of Trustees for investment of Capital Reserve funds and Managed Investment funds—to be accomplished by March, 1968.

A lengthy period of questions and answers ensued.

THE HOUSE then adopted, by a roll call vote, a motion "that the Treasurer's Report be adopted and approved, and further that The Council implement these recommendations immediately and expeditiously."

7. Consideration of Necessary Bylaws Amendments to Implement the Asset Management Plan.

The following proposed amendments were read:

Add a new paragraph [Chapter 9, Section 8 (i)] to read:

"It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge or hypothecation. It shall have the authority specifically to authorize The Council and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid."

Add a new paragraph [Chapter 10, Section 8, subdivision (a)] to read:

"The Council shall have the authority to borrow money upon the general credit of the Society. The Council shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Council shall authorize and empower the President or the Chairman of The Council, and the Secretary or the Treasurer to execute such instruments as may be required."

This was the first reading of the Bylaws Changes.

These changes were referred to the 1967 Reference Committee on Constitution and Bylaws, C. J. France, MD, Chairman.

The House recessed for a brief period so that the reference committee could consider the matters referred to it.

THE REFERENCE COMMITTEE on Constitution and Bylaws reported, when the House reconvened: "Your Reference Committee has considered the Bylaws and first addressed itself to the question of whether the proposed Bylaws changes were consonant with the Constitution, specifically Article XII entitled 'Finances,' and particularly Section 1, which reads: 'The Method of Financing. Funds for meeting the expenses of the Society shall be raised by annual dues, special assessment and voluntary contributions.' The majority of the Committee took the point of view that there was no conflict with Article XII.

"Secondly, the amendment to Chapter 9 of the Bylaws, which is entitled 'House of Delegates,' Section 8 which is entitled 'Powers and Duties of the House of Delegates,' by the addition of a new paragraph (i) was approved.

"Third, Chapter 10 of the Bylaws, which is entitled 'The Council,' Section 8 which is entitled 'Control of Funds,' with the addition of a subparagraph (a) was approved.

"Your Committee recommends approval of this Reference Committee report."

In accordance with the Bylaws, the proposed Bylaws changes were laid over for one meeting of the House.

The House adjourned for a period and reconvened at its second meeting at 5:00 p.m.

At this time the Bylaws changes were presented for the second reading.

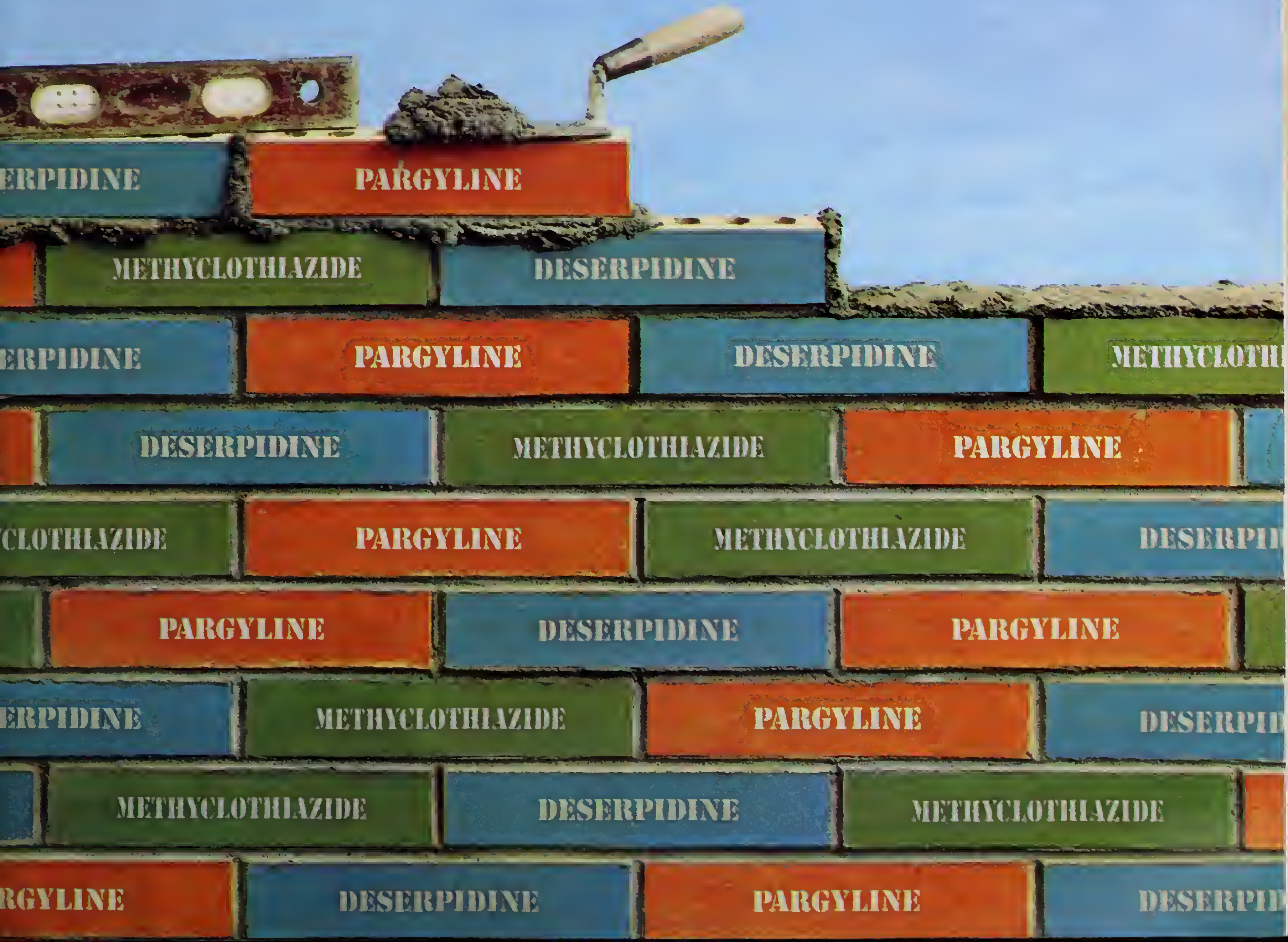
THE HOUSE adopted the report of the Reference Committee on Constitution and Bylaws.

THE HOUSE adopted a motion "that this House of Delegates sitting in Special Session authorize The Council to mortgage the corporation's building in East Lansing and to authorize The Council and its officers to execute such instruments as may be appropriate.

The House adjourned at 5:10 p.m.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension


ERPIDINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
100 No. 6812
ENDURON
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

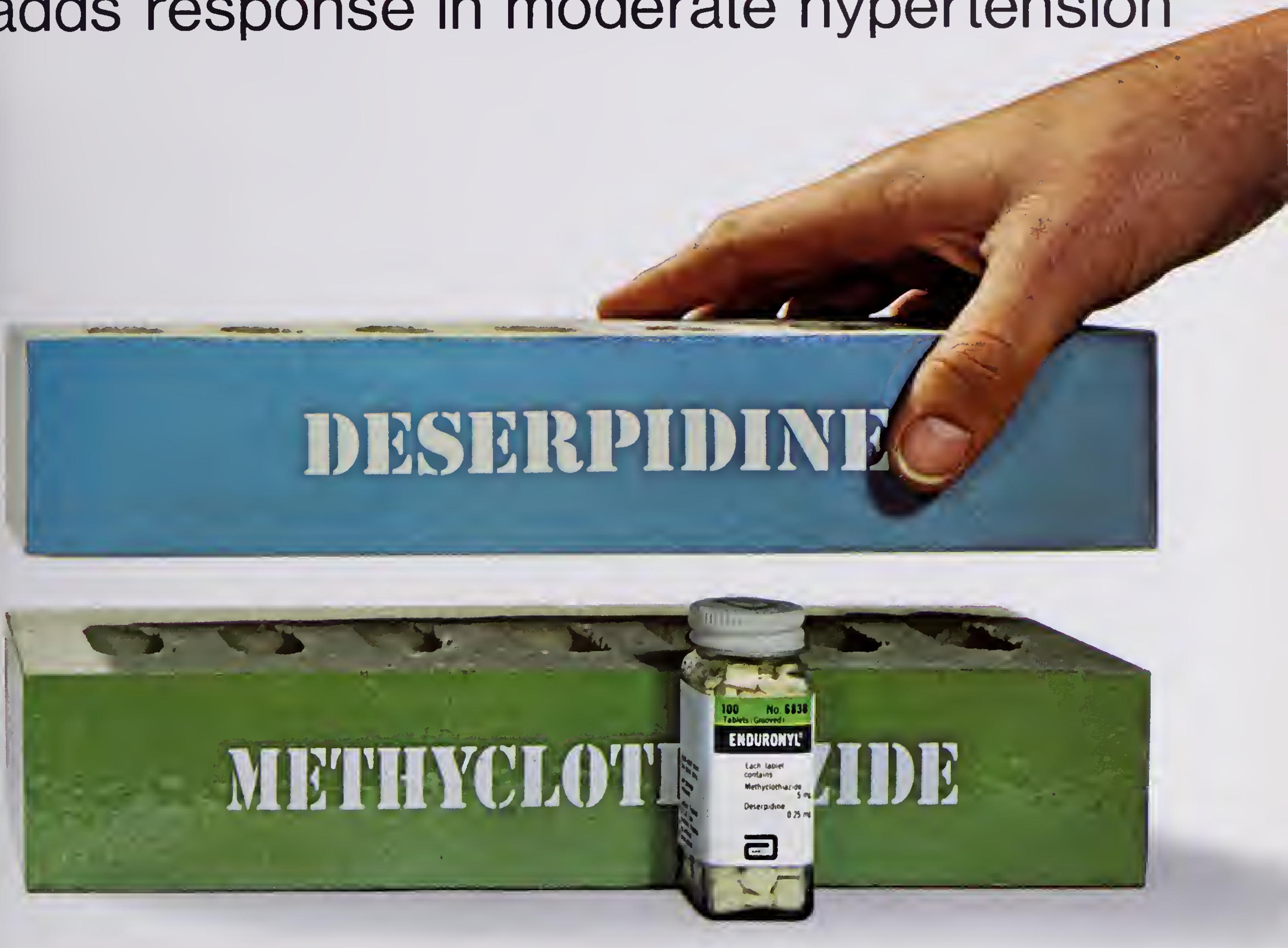
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day
ENDURON
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension


DESERPIDINE
METHYCLOTHIAZIDE
100 No. 6838
Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

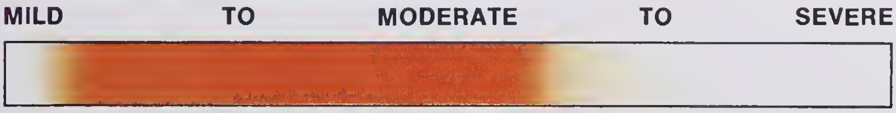
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

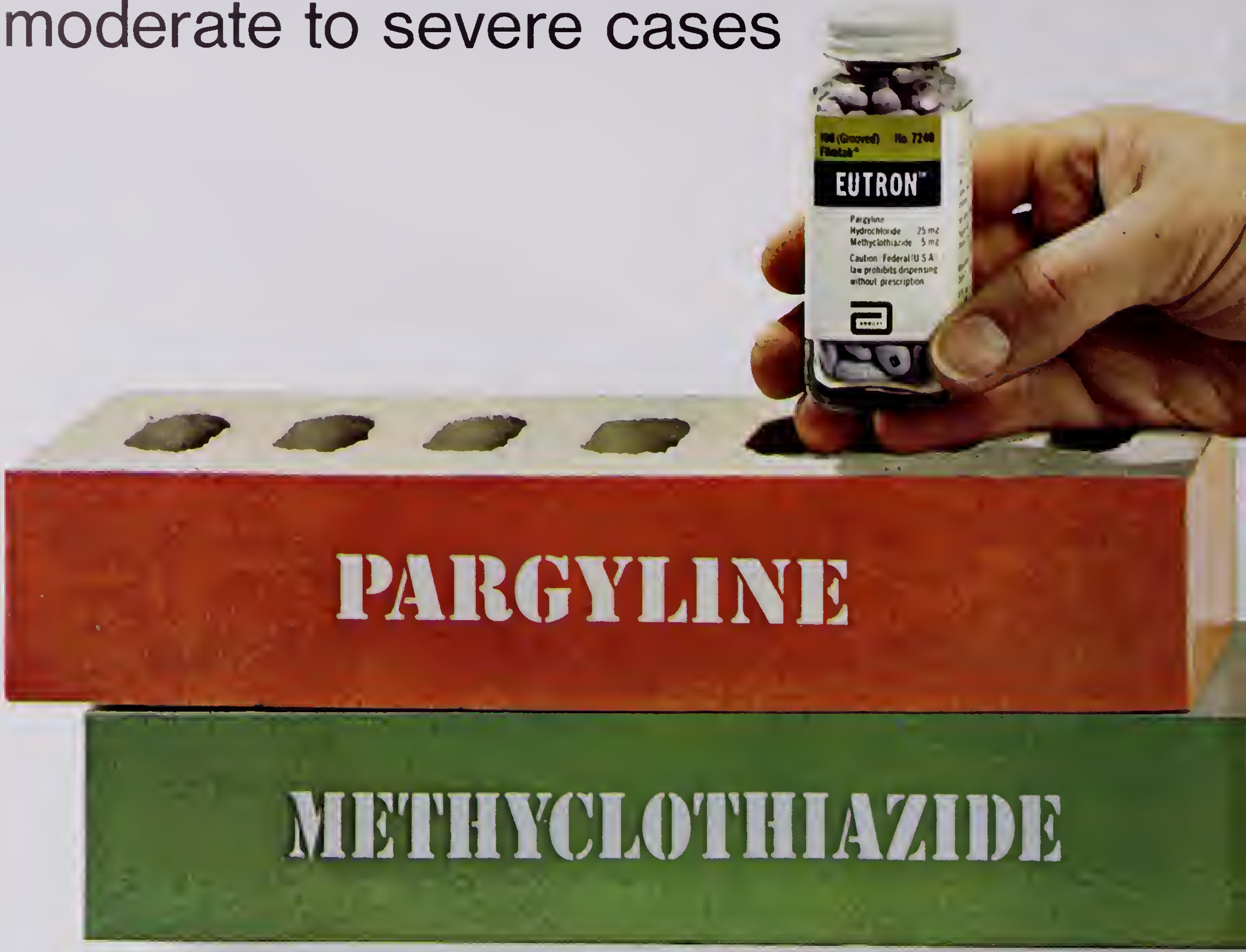
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON™
Pargyline
Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.)
law prohibits dispensing
without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

MILD
TO
MODERATE
TO
SEVERE

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

MSMS Presents Awards to Recognize Legislators, Firms, Physicians

Twenty-four coveted MSMS Awards were presented at the 1968 Awards Luncheon in Detroit February 24 as part of the First Annual Michigan Conference Health Planning.

Twelve Michigan public officials, associations, firms and foundations received "Outstanding Health Service Awards." Two MSMS members were given "Distinguished Service Awards." Ten MSMS members received the new "MSMS Flag Awards" for their leadership as presidents of nonmedical, lay statewide organizations.

(See Viewpoints, page 441, for further information about The Flag Award)

Following is a complete list of the awards, and the special citations on the handsome certificates:

Michigan State Medical Society Outstanding Health Service Awards:

Clara Elizabeth Fund (Flint)
"For generous financial sponsorship of the annual Michigan Conference on Maternal and Perinatal Welfare, convened in cooperation with the Michigan State Medical Society"

Consumers Power Company (Jackson)
"For continuing financial support to the Michigan Health Careers Mobile and other programs of health career recruitment"

Charles E. Forsythe (Secretary, Michigan High School Athletic Association, Lansing)
"For distinguished leadership in helping to solve the medical problems related to organized high school athletics in Michigan"

Grand Rapids Press
"For outstanding reporting and interpretation of news about medicine and health"

James M. Hare, Secretary of State
"For outstanding cooperation with the Michigan State Medical Society in mutual efforts to remove the unsafe driver from Michigan highways as exemplified in the Medi-Label project"

Michigan Association of the Professions
"For continuing origination of the outstanding television program, "Formula," over WJIM-TV, Lansing"

Outdoor Advertising Association of Michigan
"For outstanding cooperation in making many billboards throughout Michigan available for a special health careers recruitment appeal"

Senator Robert L. Richardson (Saginaw)
"For leadership in supporting desirable health legislation for the people of Michigan"

Sears-Roebuck Foundation (Chicago)
"For generous financial support to the Michigan Health Careers Mobile and its program of health careers recruitment"

Representative J. Robert Traxler (Bay City)
"For leadership in supporting desirable health legislation for the people of Michigan"

The Upjohn Company (Kalamazoo)
"For continuing financial support of the important MD Placement Program of the Michigan Health Council and the Michigan Health Careers Mobile"

HEALTH
PLANNI
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* * *

### Michigan State Medical Society Distinguished Service Awards

James S. Feurig, M.D. (East Lansing)
"For exemplary leadership in solving medical problems related to organized athletics in Michigan and the Nation"

Gerald A. O'Connor, M.D. (Ann Arbor)
"For exemplary leadership in solving medical problems related to organized athletics in Michigan and the Nation"

### Michigan State Medical Society Flag Awards

Carl B. Beeman, M.D. (Grand Rapids)
President of Michigan Heart Association

Donald A. Hagge, M.D. (Livonia)
President of Michigan Archaeology Society

John J. Hanlon, M.D. (Detroit)
President of Michigan Public Health Association

William N. Hubbard, Jr., M.D. (Ann Arbor)
President of Michigan Association for Regional Medical Programs

Benjamin Jeffries, M.D. (Detroit)
President of Michigan Epilepsy Center and Association

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The Upjohn Company; Donald
Meredith, representative

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WJIM-TV, Lansing;
Harold A. Gross, President

George D. Maniaci, M.D. (Gladstone)
President of Michigan Association for Retarded Children

G. Frederick Moench, M.D. (Midland)
President of Michigan Society for Better Hearing and Speech

John B. Rowe, M.D. (Flint)
President of Michigan Diabetes Association

G. B. Saltonstall, M.D. (Charlevoix)
President of Michigan Association of the Professions

H. A. Towsley, M.D. (Ann Arbor)
President of Michigan Health Council, and Michigan United Fund

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Doctor, May I Have a Political Appointment

BY REP. JAMES H. HEINZE
BATTLE CREEK

(Note: This guest article was written for *Michigan Medicine* by Representative James H. Heinze, Republican serving a district of Calhoun, Kalamazoo, and St. Joseph Counties. A retired lieutenant commander of the Navy, Mr. Heinze obtained the A.B. and LL.B. degrees from West Virginia University. He was first elected to the Michigan House in 1966.)

"Now, Doctor," I have a suggestion:

"Several 'healing arts' bills have come before the Michigan legislature. In each case laymen, unfamiliar with the details and principles of medical and 'health' disciplines, are called upon to make decisions defining certain elements of the 'healing arts' professions.

Quite frankly, we are confused and frustrated by our lack of sound and reliable information. It is often almost impossible to distinguish between objective and subjective advice and opinion. Rightly or wrongly we suspect professional jealousies and self-serving motives.

"THERE ARE A NUMBER of medical, para medical and technical professions and disciplines of the healing arts which are recognized by law, and for which statutory definitions and regulations are in effect. Under these circumstances, our job is to define properly and up-grade all of these legally recognized disciplines. For this purpose every member of the legislature needs expert, reasoned, and objective professional opinion and advice.

"It is, therefore, sincerely suggested that the state and local organizations representing medical doctors and the various divisions of specialists within that profession together with the osteopaths, optometrists, chiropractors and other disciplines undertake to set up, voluntarily, a coordinating body or committee of some kind to which the legislature can turn for objective assistance in the area of statutory regulation of these disciplines."

How would you respond, Doctor, to that suggestion? I proposed it quite sincerely to a number of my medical constituents last year while the legislature was considering several healing arts bills. This is one part of political action and deserves your consideration.

REAL AND EFFECTIVE political action, however, starts with involvement in a political party, whatever party most nearly approximates your philosophy. At this level you participate in the selection of candidates, in their campaigns, both primary and general, and in the formulation of party policy and financing of party activity. Many elements of society and industry are becoming more conscious of the necessity of this sort of involvement. Without it, the most intensive "last minute" effort to obtain consideration of your views and attitudes toward pending legislation can fall on deaf ears and be completely ineffective.

This means a budgeting of your time, an hour or two a week for political activity, committee meetings or some calls with your candidate. Anticipating your response, I hear the words, "But I'm a busy man. I have more patients than I can handle now. I can't afford to devote any substantial time to grass roots political activity."

Doctor, the hour is late. You can't afford not to! ☐

SAGINAW DOCTOR COMPLETES RESEARCH, SEES CHLORINE AS HEART MENACER

Joseph M. Price, M.D., Saginaw, has released in a 50-page report, his findings that "the basic cause of atherosclerosis and the resulting clinical entities such as heart attacks and strokes is chlorine — the chlorine contained in processed drinking water."

His conclusion is based on a 2½ year study using young chickens. In the report, he also traces the history of chlorine use in various parts of the world and indicates a "correlation between the introduction and widespread application of chlorination of water supplies and the origin and increasing incidence of heart attacks that is exceedingly difficult to explain away."

Doctor Price's experiments and conclusions were reported in an extensive feature article by John D. Tucker in the *Saginaw News.*

Doctor Price is now serving as a captain in the Medical Corps in Viet Nam. His father, Joseph A. Price, assisted in the research study.

COMING EVENTS

HEART ASSOCIATION SCIENTIFIC SPEAKERS SET FOR MAY 10-11

The Michigan Heart Association's 1968 Scientific Sessions, formerly held in February has been shifted to May 10 and 11. The location also has been changed from a downtown hotel to the Rackham Educational Memorial Building, 60 Farnsworth near Woodward, in the Detroit Cultural Center.

Hotel accomodations will be available at the nearby International Inn.

Reservation forms are available at the Heart Association offices, at 13100 Puritan, Detroit, Michigan 48227.

Theme of the session, worth seven credit hours to the American Academy of General Practice, will be the identification of various arrhythmias, their physiological implications and management.

The program, May 10, will include:

"Practical Management of Arrhythmias and Conduction Disturbances in Children" by Mary Allen Engle, M.D., Director of Pediatric Cardiology, New York Hospital — Cornell Medical Center; "Adrenergic Beta Receptors: Values and Hazards of their Blockage," Henry H. Swain, M.D., Professor of Pharmacology, University of Michigan Medical Center; "Errors in Diagnosis and Treatment of Arrhythmias and Conduction Disturbances," Robert O. Brandenburg, M.D., Chairman, Sections of Cardiology, Mayo Clinic.

The program, May 11, will offer:

"Future Trends in the Medical Treatment of Acute Myocardial Infarction," Paul N. Yu, M.D., Professor of Medicine and Head, Cardiopulmonary Unit, University of Rochester School of Medicine and Dentistry; Vice Chairman, Council on Clinical Cardiology, American Heart Association; "Future Trends in Surgery for Ischemic Heart Disease," Philip N. Sawyer, M.D., Professor of Surgery, Downstate Medical Center, State University of New York, Brooklyn, N.Y.; Wilson-Myers Lecture: "Electrophysiology of the Heart," Brian F. Hoffman, M.D., David Hosack, Professor of Pharmacology and Chairman, Department of Pharmacology, College of Physicians and Surgeons, Columbia University; "Treat the Patient, Not the Arrhythmia — and How To Do It," J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Ga.; "Rhythm and Conduction Disturbances as Insurability Risks — A Practical Assessment," Francis F. Rosenbaum, M.D., Vice President, American Heart Association, Milwaukee; "Problems with Rhythm and Conduction in Patients with Congenital Heart Disease," Robert O. Brandenburg, M.D., Chairman, Sections of Cardiology, Mayo Clinic.

The program was the work of MHA's Scientific Sessions Committee chaired by Thomas James, M.D., said Dr. Carl B. Beeman, president of the Heart Association. Other members of the Committee are: James B. Blodgett, M.D., Muir Clapper, M.D., Martin Jaffee, M.D., Thomas A. Bruce, M.D., James F. Conway, Ph.D., M.D., and Park W. Willis, III, M.D. □

CANCER DAY SET AT FLINT, MAY 1

The Genesee County Medical Society invites all physicians to attend its Eighteenth Cancer Day, Wednesday, May 1, at the Merliss Brown Auditorium at Hurley Hospital in Flint.

Welcoming participants to the morning session will be H. Maxwell Golden, M.D., president of Genesee County Medical Society. Bradley Harris, M.D., MSMS president, will preside.

Three talks are slated for the morning: "Use of Pap Smears in Diagnosis and Control of Cancer," by W.A.D. Anderson, M.D., from the Department of Pathology, Jackson Memorial Hospital, Miami, Florida; "Radiation Therapy of Primary and Metastatic Lesions to the Brain," by Jean Bouchard, M.D., Radiologist-in-Chief, Professor and Chairman, Department of Radiology, McGill University, Royal Victoria Hospital, Montreal, Canada; "How Will the Recent Federal Legislation Affect the Physicians and Cancer Patients?" by Guy F. Robbins, M.D., Director of Planning, Memorial Sloan-Kettering Cancer Center, New York, N.Y.

Presiding at the afternoon session will be Andrew J. Hunt, Jr., M.D., Dean of the School of Human Medicine at Michigan State University. The three afternoon talks are: "Responses to Therapy of Children's Metastatic Cancer and Leukemia," by M. Lois Murphy, M.D., Chairman, Department of Pediatrics, Memorial Hospital for Cancer and Allied Diseases, New York, N.Y.; "The

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In addition the AMA TV network will present more than 40 hours of convention news.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, June 19, 1968. Since space is limited, we suggest you make your reservations before June 3, 1968. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

SAN FRANCISCO, CALIFORNIA · JUNE 16-20, 1968

AMERICAN MEDICAL ASSOCIATION'S 117th ANNUAL CONVENTION · BROOKS HALL

Early Roentgen Diagnosis of Cancer of the Lung," by Benjamin Felson, M.D., Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio; and "Diagnosis and Management of Neoplasms of Lung and Esophagus," by Walter J. Burdette, Ph.D., M.D., Professor of Surgery and Resident Associate Director of the M.D. Anderson Hospital and Tumor Institute, University of Texas Medical Center, Houston, Texas. ☐

Detroit To Host Big Science Fair

The 19th International Science Fair will be held in Detroit, May 15-18.

The fair was held in Michigan once before in 1958 at Flint.

The International Fair pools the best exhibits from 10, 11, and 12th grade students who have entered their work in local science fairs.

At last year's International Fair, there were two award-winning exhibits from Michigan: one was a study of nuclear phenomenon by a student at Sault St. Marie, another was an "Electrophoretic Investigation of Protein Levels in Serum from Rats Infected with Babesia rodhaini," by a student from Holt.

The American Medical Association is one of the organizations which sponsors awards at the International Fair. Each year Citation plaques are given to one boy and one girl with best exhibits in the broad field of medical sciences or health, plus expenses-paid trip to exhibit at the annual AMA convention. Six or more Merit awards are also given. ☐

TEACHES ADVANCED AID FOR AMBULANCE PERSONNEL

An advanced First Aid course for ambulance drivers and attendants is being given by R. W. Lingenfelter, M.D., director of emergency services at Beyer Memorial Hospital, Ypsilanti.

The classes, offered in connection with the National Ambulance Training Institute, meet weekly for four hours. Twenty drivers and attendants of the Superior Ambulance Company are enrolled. Doctor Lingenfelter reports that all the drivers assigned in Washtenaw County and others from outside the county have attended. ☐

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GRIFFIN, ROUSE COMING TO DETROIT FOR SAMA EVENT

Michigan, which produced the Student American Medical Association's first president, Warren R. Mullen, M.D., now of Pentwater, will play host to the 18th Annual Meeting of SAMA, April 24-28, at the Statler Hilton Hotel, Detroit.

"This is an excellent opportunity to observe your colleagues of tomorrow in an atmosphere that will surprise, as well as warm the hearts of those who fear for the future of medicine," says SAMA President David Kindig, in extending an invitation to all Michigan doctors.

The 1968 meeting is being planned by the national SAMA officers and the three SAMA chapters in Michigan at Wayne State, University of Michigan and Michigan State.

Highlights will include a lecture April 25 by USPHS Surgeon General William H. Stewart, M.D.; a symposium on "The Care and Feeding of Hippies," on April 25; a speech by Michigan Senator Robert P. Griffin at the annual American Medical Political Action Committee April 26; and a symposium on "The Physician's Personal Problems" April 26.

AAGP President George E. Burket, Jr., M.D., Kingman, Kans., will be guest speaker at an April 26 luncheon sponsored by the Academy.

AMA President Milford O. Rouse, M.D., will speak April 27 at the annual luncheon sponsored by the AMA.

Interested physicians can register in advance by sending a letter (general registration fee $2.00 — Award Banquet and Reception $5.00 additional) with check or money order to: SAMA, 2635 Flossmoor Road, Flossmoor, Illinois 60422, to assure advance registration. ☐

Detroit to Salute WSU on June 13

The City of Detroit, under the leadership of 100 distinguished citizens, will honor Wayne State University's 100th Anniversary at a banquet June 13.

Timed to coincide with the 100th Anniversary date of the issuance of the charter to the School of Medicine, the first Wayne college, the banquet, to be held at 7:00 p.m. in Cobo Hall, will feature Erwin Canham, editor of *The Christian Science Monitor,* as its main speaker.

Honorary chairmen for the banquet are Mayor Jerome P. Cavanagh and Governor George Romney. General Chairman is Walker L. Cisler, chairman of the board of Detroit Edison. ☐

MEDISCENE

April 17 — The Council, MSMS Headquarters, East Lansing

April 17-18 — Annual Conference for Directors of Research in Medical Education, Kellogg Center, East Lansing

April 22-25 — Joint meeting of the American Association of Physical Anthropologists and the Study of Human Biology, Detroit

April 23-28 — 17th National Convention of the Student American Medical Association, Statler-Hilton Hotel, Detroit

April 24 — Michigan League for Nursing, Annual Meeting and Board of Directors Meeting, Mercy College Student Center, Detroit

April 24-25 — County Medical Care Facilities Conference, Kellogg Center, East Lansing

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, M.S.U., East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 6-8 — Michigan United Fund, Kellogg Center, M.S.U., East Lansing

May 8-10 — Michigan Public Health Association, Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 17-18 — Junior Academy of Science, Kellogg Center, East Lansing

May 18 — Kresge Eye Institute Clinic Day, Detroit

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 16-20 — 1968 AMA Annual Convention, San Francisco

June 28-29 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor ☐

ACTIVITIES, PROJECTS

COMMITTEE OFFERS MSMS SPEAKERS ABOUT ALCOHOLISM

Aware of the problem which the private practice physician faces in treating alcoholics, the Committee on Alcoholism and Drug Addiction has decided to continue its physician education effort in 1968.

Chairman Herbert A. Raskin, M.D., of Detroit, reports county medical societies, specialty societies, and chiefs of hospital staffs will be contacted and informed of the availability of committee members and other experts for speaking engagements.

"We hope to give the practitioner of general medicine the knowledge required for diagnosis and treatment of alcoholics," Doctor Raskin said. "Alcoholism involves medical, sociological, and psychiatric problems and we hope to help the physician deal with these."

Doctor Raskin says speakers are available to discuss "How to diagnose and treat alcoholism," "What can be done with the alcoholic in the hospital," "Requirements for post-hospitalization care," "Over-all picture of purely medical problems and the emotional factors involved," "Emotional factors which the non-psychiatric physician can handle," "Physician's role in terms of the sociological problems of the patient," and "Physician's role in the community public health problems involved in alcoholism."

Any hospitals or organizations having general or specific questions they want discussed should contact Herbert Raskin, M.D., at 18510 Meyers Road, Detroit 48235. Arrangements should be made, if possible, one month in advance of the speaking date. ☐

PRINTING OFFICE OFFERS NEW NATIONAL REPORT

Interested physicians may obtain copies of the *Report of The National Advisory Commission on Health Manpower* from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Price, 45 cents.

MDPAC ELECTS BASS, ANTHONY, LAHTI; HONORS COLE

At its recent meeting in Detroit, the Michigan Doctors Political Action Committee re-elected Vernon V. Bass, M.D., of Saginaw, as state chairman.

George Anthony, M.D., of Flint, was re-elected as treasurer.

Paul T. Lahti, M.D., of Royal Oak, was chosen as a new member-at-large of the MDPAC Board of Directors.

During the meeting a handsome plaque was presented to W. C. C. Cole, Jr., M.D., Detroit, thanking him for his two years of service as the chairman. ☐

MICHIGAN MD DRAFT MAY TAKE 30 IN '68

The Michigan Selective Service reports that no final decision has been made yet about how many doctors will be drafted this year; but estimates have been made that place the figure at about 30.

About 1,100 physicians will be drafted from the United States in 1968. This is about half the number which were called in 1967.

In 1967, 59 Michigan doctors of medicine were commissioned, as well as 40 doctors of osteopathy.

Seminars Offered On Group Psychotherapy

The Wolverine State Group Psychotherapy Society, local affiliate of the American Group Psychotherapy Association, is holding a series of spring seminars in Ann Arbor and Detroit for members and interested professionals.

"Multi-transferences in Group Therapy" will be discussed by Max Sugar, M.D., New Orleans, Saturday, April 20, at 2:30 PM in the McGregor Memorial Conference Center at Wayne State University.

Milton M. Berger, M.D., New York, will speak on "The Flexible Use of Individual, Group, Family and Group Therapy" on Saturday, May 4, at 2:30 PM in Ann Arbor, at the Children's Psychiatric Hospital.

On Saturday, June 8, Hyman Spotnitz, M.D., New York, will lead the last seminar in the series at 2:30 PM, again at the McGregor Memorial Conference Center.

Cost of each seminar for non-member professionals is $2.00. Dinner will follow the meetings and spouses and friends of participants are welcome.

Reuven Bar-Levav, M.D., of Detroit, is president of the society; Stanley Woollams, M.D., of Ann Arbor, is president-elect. ☐

State Flying Physicians Help Direct F.P.A.

The Flying Physicians Association now has 69 members from Michigan with David C. Boyce, M.D., Grand Rapids, and William C. Van Gelder, M.D., Muskegon, serving on the Board of Directors.

Founded in 1954, the Association is constantly increasing its membership as more and more physicians take to the skies in their own airplanes.

The 2,000 members, who come from the USA, Canada, Puerto Rico, Australia, West Germany, West Indies, and the Republic of Congo, form a society of private pilots dedicated to the promotion of general aviation safety through example and teaching.

"We feel that we are a unique organization in that we are the only medical group specifically organized to promote aviation safety and also stimulate a medical interest in aviation among other physicians," says George Gumbert, M.D., of Lexington, Kentucky, president of the Association. "We are a completely self-supporting group with no financial aid from any governmental agency."

Doctor Boyce explains that, "The Association works closely with such groups as the F.A.A. and Air Traffic Control. Besides aviation information, our national meeting has become more and more involved in scientific medical presentation."

"We regularly sponsor group flights to various medical meetings, publish a monthly newsletter, and a quarterly called *The Flying Physician*," said Doctor Boyce.

Membership in the Association is open to all licensed physicians who are members of medical societies approved by the FPA Board of Directors, and who hold pilot certificates. In addition, membership is open to medical students, interns, and residents, as well as to any physician interested in aviation or aviation medicine even though he may not own a plane or fly.

Further information about the Association can be obtained from The Flying Physicians Association, Inc., 332 South Michigan Avenue, Chicago 60604. □

Rheumatic Fever Study Started at U-M

Questionnaires are being mailed to selected internists, pediatricians, general practitioners, and local health officers by the "Michigan Rheumatic Fever Study" being conducted by the Maternal and Child Health Research Unit of the School of Public Health, University of Michigan, at 343 S. Main St., Ann Arbor. □

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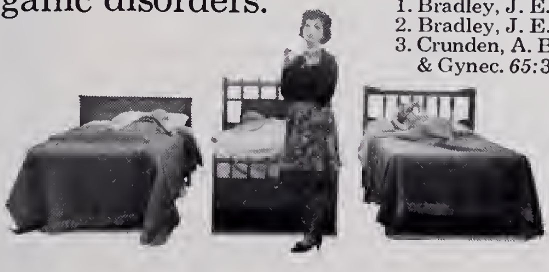
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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May 15

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DETROIT

Registration Opens: 8 a.m.

The Wayne State University School of Medicine Alumni Association's Annual Clinic Day and Alumni Reunion Wednesday, May 15, in the Sheraton-Cadillac Hotel, Detroit, will be celebrated this year during the University's Centennial. It will be especially significant to medical alumni since the University's founding dates from the first classes held by the Detroit Medical College in 1868.

Beginning with 8 a.m. registration, events of the day will include five scientific programs during morning and afternoon sessions, the Association's annual meeting, and a complimentary luncheon.

Highlighting the annual Reunion Dinner-Dance will be class reunions and the presentation of Golden Anniversary diplomas to the Class of 1918.

Dr. Duncan J. McColl, class of 1893, who was born in the same year as the Medical School, will receive the Centennial Alumni Award.

Scholarship awards and other honors will also be presented, including Distinguished Service Citations to four medical alumni. They are Peter J. Talso, M.D., professor and chairman, department of medicine, Loyola-Stritch School of Medicine; Fred Harbert, M.D., chairman, department of otolaryngology, Jefferson Medical College; Edwin T. Nishimuru, M.D., chairman, department of pathology, University of Hawaii School of Medicine; and Jules H. Masserman, M.D., chairman, department of psychiatry, Northwestern University School of Medicine.

Alumni and other doctors of medicine are cordially invited to participate in the Clinic Day Program. Reservations for the clinical program and dinner dance may be made by writing Alumni House, Wayne State University, Detroit, Michigan 48202.

MARIO A. PETRINI, M.D.

ALUMNI ASSOCIATION PRESIDENT Mario A. Petrini, M.D., will be chairman of the morning session of the Scientific Program.

TOASTMASTER at the Reunion Banquet will be Jack Ryan, M.D., a 1955 graduate who is also a national collegiate debate champion. Dr. Ryan is a senior partner at the Memorial Clinic, Warren, Michigan and, among other affiliations, is a member of the Board of Governors of WSU Medical Alumni.

JACK RYAN, M.D.

ALUMNI CELEBRATE CENTENNIAL AT SCIENTIFIC PROGRAM

MORNING SESSION

Clark Vincent, Ph.D.

Robert Coombs, Ph.D.

Peter Martin, M.D.

CLARK VINCENT, Ph.D.: "Human Sexuality — A Broad View." Dr. Vincent, who received his Ph.D. degree from the University of California at Berkeley, is director of the Behavioral Sciences Center and professor of sociology at the Bowman Gray School of Medicine.

ROBERT COOMBS, Ph.D.: "Acquired Sex Attitudes and Information — Role of Home and Parents." A graduate of Washington State University, where he received his Ph.D. degree, Dr. Coombs is an assistant professor of sociology, Behavioral Sciences Center, Bowman Gray School of Medicine.

PETER MARTIN, M.D.: "Changing Sexual Expectations in Women — The Special Role of the Physician's Wife." Dr. Martin, a 1942 graduate of Wayne State's School of Medicine, is clinical professor of psychiatry at WSU and the University of Michigan.

AFTERNOON SESSION

Harold I. Lief, M.D.

Richard H. Klemer, Ph.D.

RICHARD H. KLEMER, Ph.D.: "Marriage and Sexual Problems in Modern Society: An Overview of Pre-Marital and Marital Counselling." Clinical professor of family studies in the department of psychiatry at the Bowman Gray School of Medicine, Dr. Klemer is also professor and chairman of child development and family relations at the University of North Carolina at Greensboro.

HAROLD I. LIEF, M.D.: "Psychodynamics of Teaching Medical Students Sex Education." Director of the Division of Family Study of the department of psychiatry, University of Pennsylvania School of Medicine, Dr. Lief received his medical degree from New York University.

PANEL MEMBERS: Question-and-Answer Period.

MICHIGAN COUNCIL TO STUDY ABORTION FORMED RECENTLY

"Two years ago a public discussion of abortion would not have been easy to do. Today the climate is different," said Jack Stack, M.D., of Alma, at a news conference following the first official meeting of the Michigan Council for the Study of Abortion, Inc.

Aware that abortion is a complex matter requiring study and discussion from a number of viewpoints, the MCSA will conduct in depth studies and disseminate information in an effort to promote a climate of rational discussion in the context of accurate information about abortion.

"We want to make information available to professionals, organizations, and interested citizens," said Doctor Stack, who was elected a vice-president of the organization at its first meeting in Detroit on January 24.

"We strongly feel that we don't have all the answers to this problem," Doctor Stack continued. "We're going to conduct research and study, not lobbying."

The MCSA grew out of months of discussion which resulted in the consensus that little was known about the medical and legal problems relating to abortion and that there should be one group which could foster research and study in that area.

A decision was made to affiliate with the Association for the Study of Abortion, Inc., in New York. Persons from the State Health Department, Public Health Department, Michigan Human Resources Commission, the Florence Crittendon Home, the Michigan Women for the Medical Control of Abortion, the Michigan Council of Churches, the Protestant Episcopal Church, the Lutheran Church in America, the Michigan State Medical Society, and the Medical Schools at Wayne State, University of Michigan, and Michigan State, were involved in the decision to organize the MCSA.

MSMS representative to the Council is William H. Plesscher, M.D., of Lansing.

The organization will research questions such as: How many abortions are performed in the state of Michigan annually? Are all illegal abortions performed by non-medical personnel? How many hospitals in Michigan perform abortions? What is the opinion of the medical profession regarding abortion? For what reasons are abortions performed in accredited hospitals? What is the mental health effect of in-hospital medical abortions as opposed to back alley, underworld abortions?

Several Michigan physicians were elected to the Board of Directors of the organization. They are: Tommy Evans, M.D., professor and chairman of the department of obstetrics-gynecology at Wayne State University School of Medicine; William Goins, M.D., Director of the Detroit Maternal Infant Care Project; Ralph Rabinovitch, M.D., Director of the Hawthorn Center in Northville; Roy Smith, M.D., from the Bureau of Maternal and Child Health at the Michigan Department of Public Health; J. Robert Willson, M.D., chairman of the department of obstetrics-gynecology at the University of Michigan Medical School; and Rudolph A. Wyatt, M.D., obstetrics-gynecology representative of the Detroit Medical Society.

The organization will regularly publish a newsletter and results of studies. Members will also receive information from the national organization.

Further information on membership application may be obtained by writing the Michigan Council for the Study of Abortion (MCSA), 29575 Milton, Madison Heights, Michigan 48071. □

Marquette Ophthalmologist Back From Haiti Clinic

Harry Koenig, M.D., Ishpeming, spent the month of February in ophthalmological work at a clinic in Cayes, a depressed area on the south coast of Haiti.

The clinic at Cayes was established in 1963 by Focus, Inc., an Illinois non-profit corporation designed to give practicing American physicians an opportunity to represent their profession and country by working for a month, without payment, in needy areas overseas. Under the agreement with the Haitians, the volunteering physician pays his own flight transportation to Port au Prince, the capital, as well as hotel accommodations until he reaches his destination. The Haitians supply room and board and transportation in the clinic city, as well as a translator, ancillary personnel, and hospital beds.

Doctor Koenig did a great deal of surgery for bilateral mature cataracts and also saw many outpatients at the clinic in Cayes, which is about seven hours by jeep from Port au Prince.

Formerly chief of staff at Bell Memorial Hospital, Doctor Koenig is president-elect of the Marquette County Medical Society. □

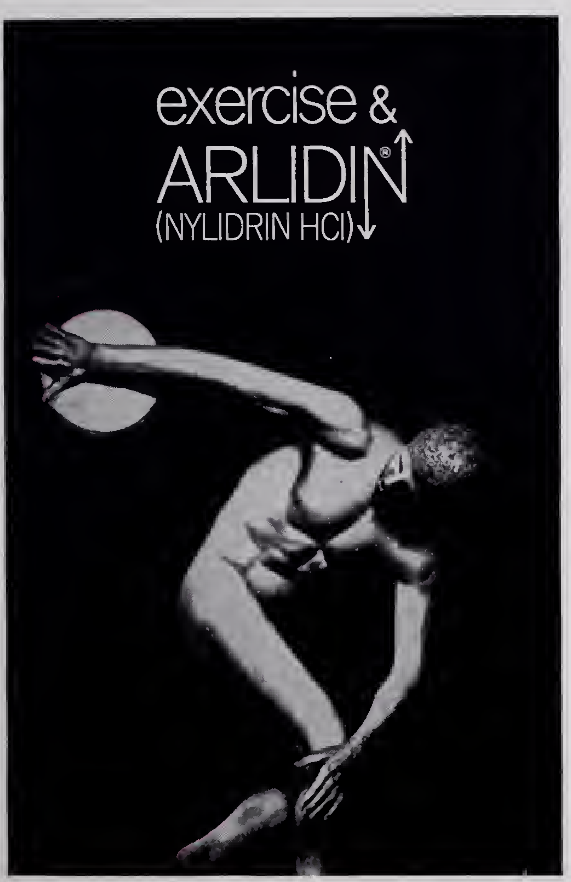
AMA, ASCP JOIN IN APPROVED PROGRAM FOR LAB ASSISTANTS

The AMA Council on Medical Education has established, in cooperation with the American Society of Clinical Pathologists, an approved program for certified laboratory assistants.

Upon completing an accredited 12-month course of hospital or laboratory school training and passing an examination, graduates are designated as certified laboratory assistants. To meet the increased demands for laboratory service, it is estimated that 100,000 certified laboratory assistants will be needed by 1975.

The current list of AMA-approved schools for laboratory assistants, as well as lists of other AMA-approved or accredited schools — cytotechnology, inhalation therapy technician, medical record librarian, medical record technician, medical technology, occupational therapy, physical therapy and x-ray technology — may be obtained by writing the AMA's Department of Allied Medical Professions and Services.

A six-page pamphlet, "A Career for You as a Certified Laboratory Assistant," may be obtained by writing the Secretary, Board of Certified Laboratory Assistants, 445 N. Lake Shore Drive, Chicago, Illinois 60611.



Goodsell to Lead U-M Medical Alumni

John O. Goodsell, III, M.D., of Saginaw, has been elected 1968 chairman of the University of Michigan Medical Center Alumni Society's board of governors.

He succeeds George W. Slagle, M.D., of Battle Creek.

MPH FELLOWSHIPS AVAILABLE AT U-M

A study program leading to a Master of Public Health degree, with emphasis on chronic disease, adult health, and aging, at the University of Michigan School of Public Health is now accepting applications for 1968-69.

The invitation to apply is extended to students with a B.A. or an advanced degree in the health field or social sciences.

For further information contact Ian T. Higgins, M.D., Program Advisor, Chronic Disease, Adult Health and Aging, The University of Michigan School of Public Health, Ann Arbor, Mich., 48104.

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REQUIRED

A successful doctor-sponsored medical care plan requires a Medical Director. This is a senior executive position requiring a minimum of 5 years experience in the practice of medicine. Administrative ability is a distinct asset as are interest and knowledge in the field of medical economics.

Position open May 1, 1968. Salary open to negotiation.

Reply in confidence giving full details as to age, education, experience and qualifications to: **Dr. Alan Taylor, Windsor Medical Services Inc., Windsor, Ontario.**

Medical evaluation is an important first step toward rehabilitation; in programs of the National Society for Crippled Children and Adults. Doctors direct the work of Easter Seal therapists to help crippled and adults overcome their handicaps.

Urges County Societies To Take Advantage Of Michigan Week

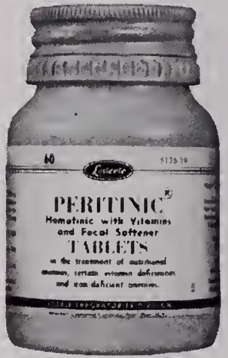
"Michigan Week, to be held May 19-25, presents county medical societies with an opportunity to focus on a number of medical concerns," says Brock E. Brush, M.D., chairman of MSMS Public Relations Committee.

"For example," Doctor Brush said, "the theme for Saturday, May 25, is 'Our Youth.' A medical society could arrange with local high schools to invite selected students interested in the health profession for a workshop on the various careers in the health field. There are excellent films and printed material on this subject, and countless ways in which an educational and inspirational program could be set up for students."

"Livelihood Day" on Wednesday, May 22, or "Education Day" on May 23 are also possibilities, Doctor Brush said. "While the students are at school, a physician could give a talk on the opportunities and need for doctors today. I am sure many schools would cooperate in this."

"There are many ways in which county medical societies can take the initiative in Michigan Week, and the MSMS Public Relations Committee, which can be contacted through MSMS headquarters in Lansing, stands ready to help county societies in any way possible," Doctor Brush concluded.

anticostive* hematinic



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Vitamin B_1	7.5 mg
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Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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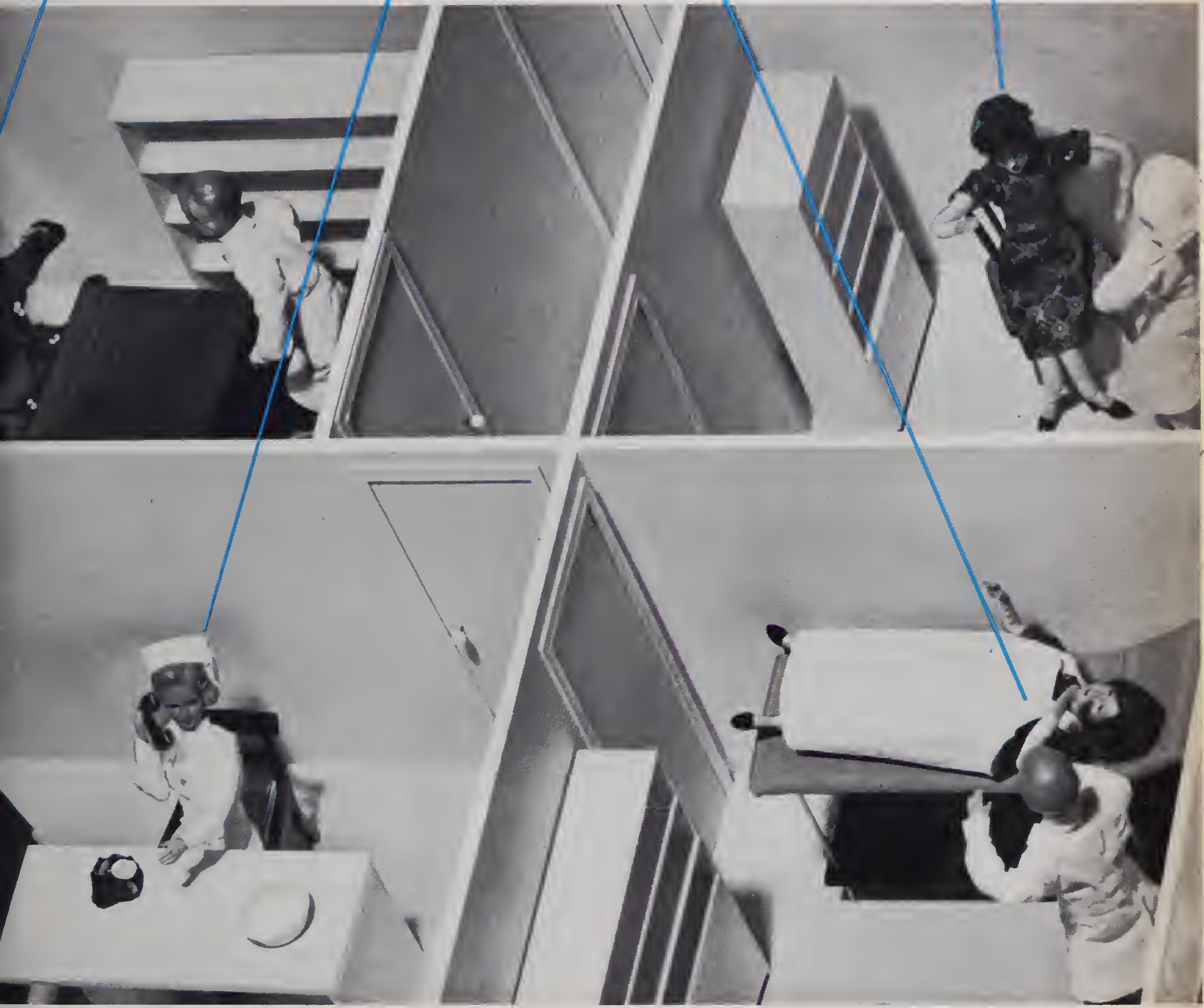

he asks for your help,
ut just can't seem
o follow through
n your advice.

When not at your office,
she's constantly
on the phone: can't sleep,
headache, G.I. upset.

She often seeks a
physical explanation
for her distressing
emotional state.

She's excessively
apprehensive;
demands much more of
your nurse's attention.

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Mellaril helps control the most frequent symptoms: marked ension, agitation, apprehension, restlessness, hypermotility

Mellaril often alleviates anxiety-induced somatic complaints

Mellaril frequently helps strengthen emotional resources

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ontraindications: Severely depressed or omatose states from any cause, and in ssociation with or following MAO inhibiors; severe hypertensive or hypotensive eart disease.

recautions: Hypersensitivity reactions e.g., leukopenia, agranulocytosis) and onvulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

for moderate to severe anxiety

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68-115

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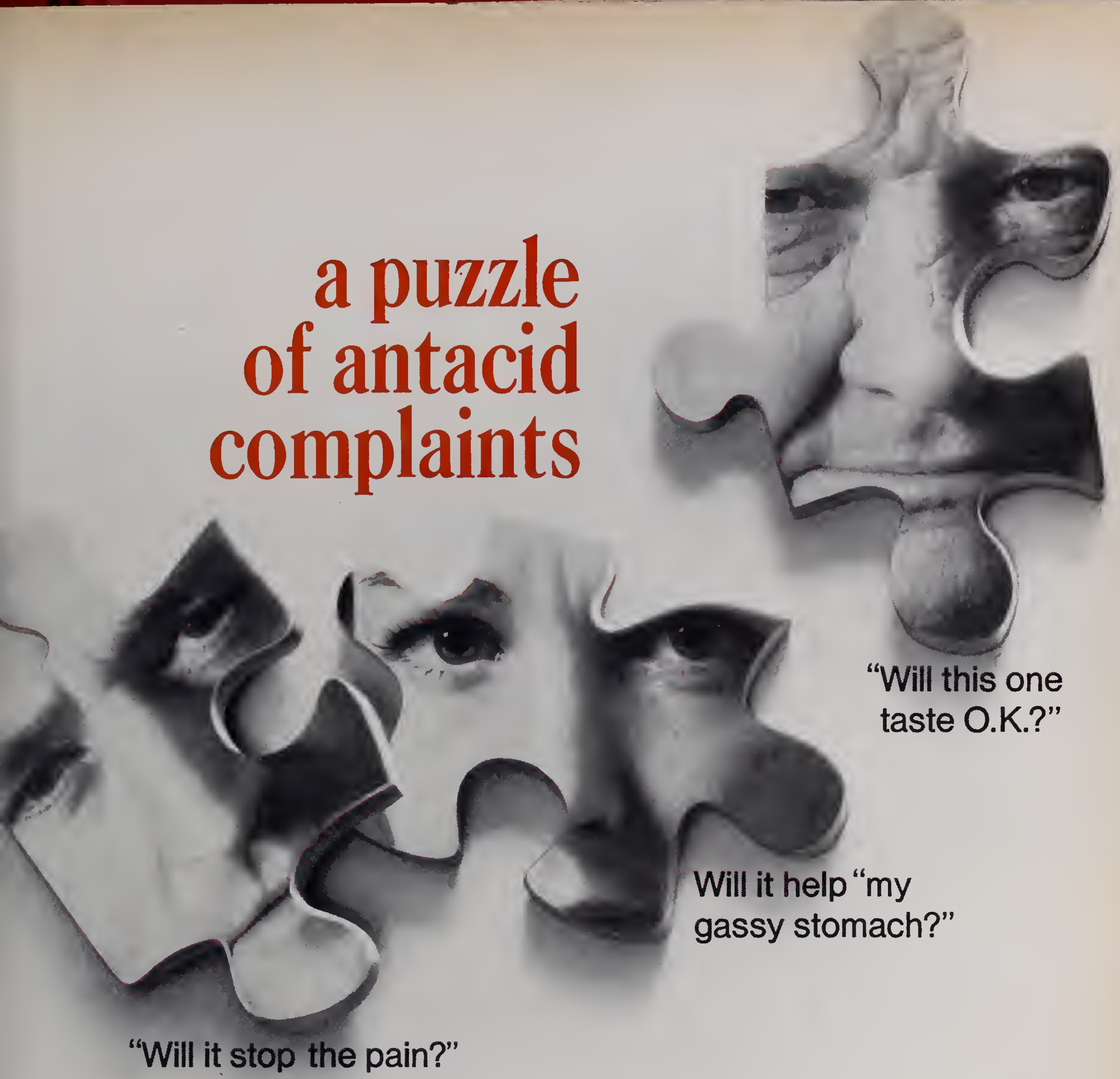
Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

a puzzle of antacid complaints


"Will this one taste O.K.?"
Will it help "my gassy stomach?"
"Will it stop the pain?"

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aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

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Concomitant relief of G.I. gas distress—
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Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

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As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

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NTz is more than a simple vasoconstrictor. It contains

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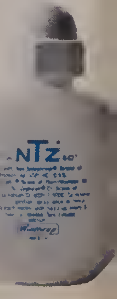

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	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
scyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
pine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
scine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
nobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
rning: may be habit forming)			

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Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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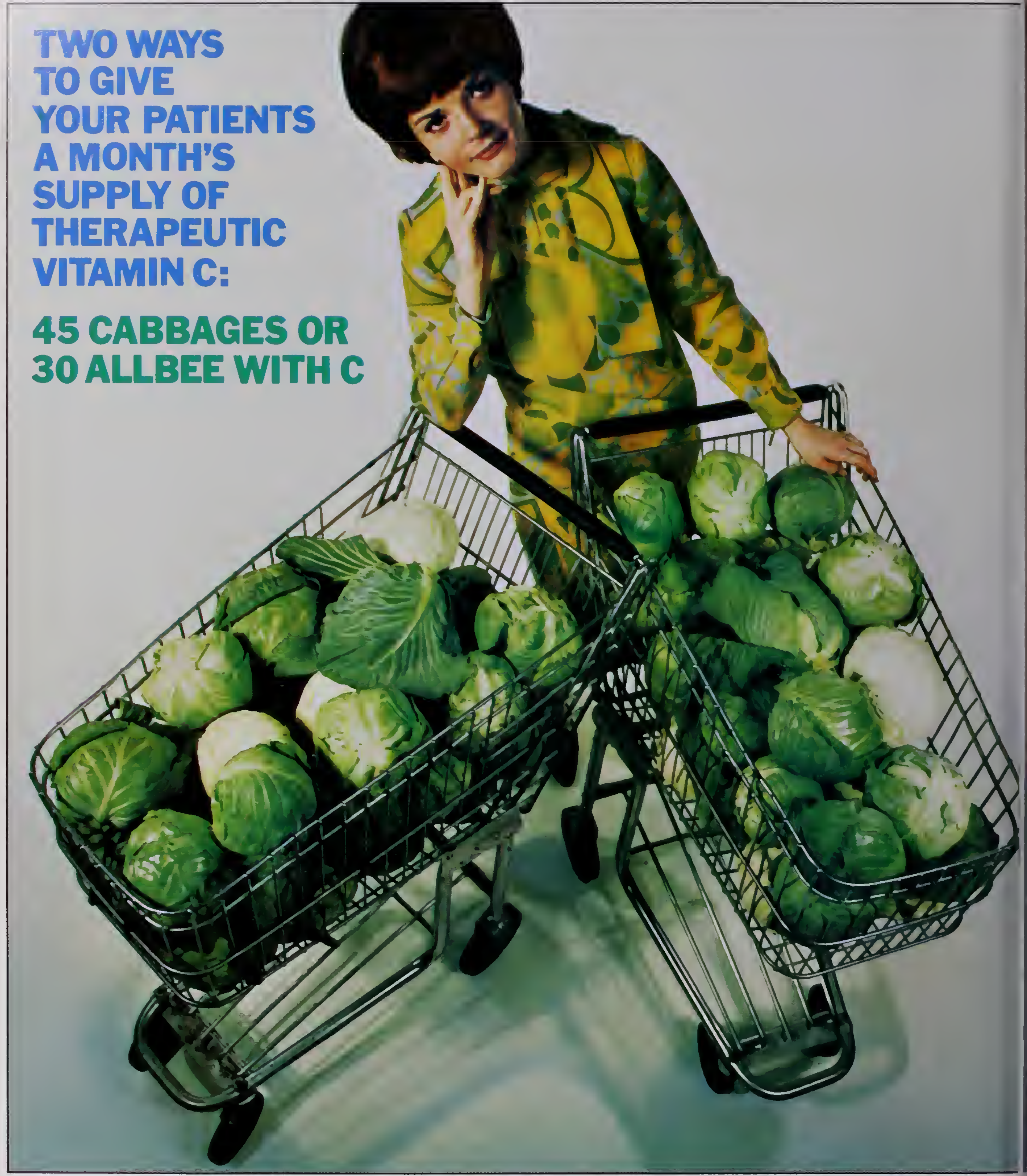
TO GIVE
YOUR PATIENTS
A MONTH'S
SUPPLY OF
THERAPEUTIC
VITAMIN C:

45 CABBAGES OR
30 ALLBEE WITH C



Your patient would have to eat 45 cabbages a month (1-1/2 a day) to get as much vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak.

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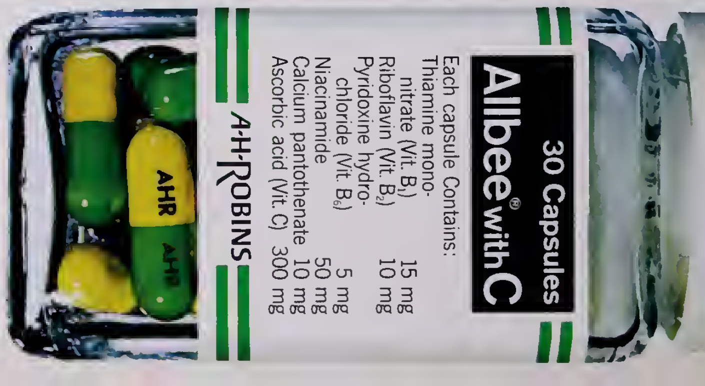
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Each capsule Contains:
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Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg
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AHR

BLUE SHIELD PRESIDENT ASKS:

How Common Is Our Cause?

The reality of the question before us is not the existence of Blue Shield but the extent, the shape, of that existence in the future of medicine in Michigan.

The reality is that in the year just passed, Michigan Blue Shield paid approximately $175,470,000 for well over six million claims involving more than twelve million services to the sick and injured among the more than 5,499,000 persons — more than half the population of the state — covered by its programs.

The reality is that most cautious business projections show that this year the payment figure will be more than $200,000,000 for more than seven million claims.

The reality is not those millions of people and dollars themselves but the *reasons* which placed those millions on, shall we say, the *ledgers of medicine,* under Michigan Blue Shield.

Those reasons distill to a *single, simple* one:

IT IS THIS:

The cause of private medicine in Michigan and the cause of Michigan Blue Shield is a common cause.

It always has been.

There is *nothing* in Blue Shield's future to change it.

When your colleagues first explored the idea of what was to become Blue Shield, in a meeting of the Michigan State Medical Society in Battle Creek in 1931, they had to overcome barriers set up in their ethical law to prevent their taking part in what might have become "an economic undertaking."

I could flossy-up this discussion with emotion about near-starvation in our land in those days, and about the incidence of diseases previously associated only with, say, the Ganges, but that would be pointless.

The true point of reality is men of medicine saw that their cause needed what was to become Blue Shield.

The barriers were knocked down, one by one, not like the walls of Jericho in final triumphant blast and shout but in quiet and patient work.

The most essential part of that work assures that Blue Shield would not be a commercial enterprise, an "economic undertaking," but would be a means of service alone, with free choice of physician, with limitation of benefits to service, with exclusion of profit.

This took time. It took really until 1940 to implement the slowly developed plans. And it became apparent immediately that the concern for cause, the cause of medicine, as set forth in this new invention of Blue Shield, was far ahead of itself.

The first plan was to offer, in effect, comprehensive full prepaid medical care in home, in the physician's office, in hospital.

PLEASE REMEMBER this first goal. The goal was right. The know-how was not.

In little more than a year the program was $500,000 in debt and had a bank balance of $2,000. Benefits had to be reduced on a pro-rated 20 per cent basis. The struggle continued, and in June, 1942, the comprehensive part of the plan was shelved. Benefits were limited.

To condense this history, in 1944 doctors were repaid their withheld pro-rata funds. In 1945 the State Society was repaid the $10,000 — yes, $10,000 — which had been borrowed for original capital, plus $7,500 — yes, $7,500 — which had been borrowed in driblets in the worst times.

But in 1948 Michigan Blue Shield won a national award for being the first state plan to enroll a million members.

That was twenty years ago, painful as it may be for many of us here to add up the years. Many things have happened to Blue Shield since, but they total realities of growth in a common cause.

Not one branch, or twig, or leaf of that growth was put forth without the knowledge and guidance of Michigan medicine, acting through the representative and preponderant position which it

(Note: The following is a speech by John C. McCabe, President, Michigan Blue Shield, before a recent meeting of the Oakland County Medical Society. I personally believe the message deserves early printing for all the MSMS members to read. —Brooker L. Masters, M.D., Chairman, Publication Committee.)

Diarrhea
TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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CONTINUED: HOW COMMON?

has always had and has tonight on the Blue Shield Board of Directors.

Oh, there were troubles in those twenty years. There are some now.

In the M-75 program, which was a pioneer when it was first proposed, the nation's economy ran away from income fee levels. Fewer and fewer persons had their prepayments cover their total care. People said even their increased income did not leave enough to meet the differences between your fees and our schedules.

This is a past matter. We are discussing present reality and about the oneness of our cause. Permit me to continue with this immediacy in our minds.

As those troubles persisted, and as you and your patients became increasingly irked by these fixed fee levels and patient income classifications, by such things as slow recognition of specialties, by all the signs of what you might call obsolescence of what you and Michigan Blue Shield had devised, medicine and Shield went back to that original search for common effort for common cause.

In a year of intensive study, starting in July, 1966, a Blue Shield committee which was always preponderantly composed of physicians renewed this search and found what is in substance the Variable Fee and Extended Benefits Program we are beginning to implement now.

The search involved question and answer meetings with representative physicians and laymen throughout the state during the year, and free exchange of ideas. The committee, management and staff traveled many hundreds of miles and worked many hundreds of hours. The committee members cannot be too highly commended.

The program is not invention. It is not synthesized. It is a successful attempt to reflect appropriate equity with respect to both those who render service and those who pay for it.

THE CONCEPT OF reasonable, customary and prevailing fee was proposed in resolution Number 29 of the House of Delegates of the Michigan State Medical Society in its 1966 convention. The language of the Blue Shield concept is the exact language, to the comma, of the House.

The extended benefits part of the program puts in one package all of the improvements which Blue Shield had been able to add, in amending riders, to the M-75 program since inception, and extends days and types of care in all ways which medical experience and Blue Shield actuarial studies has shown possible and needed.

The home and office care part of the program, adds one essential weapon of medicine: to strike at disease early, when it may yet be weak and may be conquered, before it has ravaged man — the man who quite commonly does not seek your help until he is struck down, because he is insured only for catastrophe.

The prescription drug part of the program is also an essential arm in our mutual cause. I am sure that there is not a physician here who does not know, no matter how affluent his patients, that many a prescription goes unfilled because of cost, no matter on what other terms the patient may rationalize it to you and himself.

Do you doubt that money is the cause? In 1967, under Medicaid, Michigan Blue Shield paid more than 2,000 pharmacists for more than 1,500,000 prescriptions. Studies show that practically all prescriptions in this population, were filled.

But these are realities of the *future,* even if it is the immediate future. The reality now is the matter of your participation in the new program, and how that participation serves our cause.

I WOULD ASSUME that all of you here know the criteria of establishing what we call, under the new program, the Variable Fee. You have each received literature from us describing its development, and full discussions concerning it have appeared in many of your Bulletins and Journals and in the national medical press. Let me most briefly go over this criteria for establishing *reasonable charge levels.*

Your fee for any service will be paid in full, without regard to patient income, when it is your *customary* one for such service, when it falls within the *prevailing range* of fees charged for such service by your colleagues in your own general socio-economic environment.

Let me interject again here now the fact that these criteria came from no Blue Shield conference but came from your House of Delegates.

One immediate objection from some areas was that existing fee schedules would be used to establish the new ranges. This is not correct. The ranges being developed are using as a source your charges, not your Blue Shield payment.

A second objection was based upon the mistaken belief that ranges would be established by political community alone, or would be statewide, or would be established by various other means of distinction which would be manifestly unfair.

The truth is that ranges are being established based upon size of community or communities and such factors as area of state, in recognition of the exact differences in such fee determinants in the past.

A third objection came from an uneasy feeling that the idea of prevailing range meant that the

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Each tablet contains:

Potassium Iodide	195 mg.
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Iodide contraindications: tuberculosis, pregnancy.

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MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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physician at the lowest end of the range, let us say that kindly doctor beloved of Hollywood, whose standard fee for a heart transplant is a peck of potatoes, that this man's standard would drag down that of all of his colleagues.

The objection did not take into account the fact that each region of such establishment includes many, many hundreds of physicians, at least, and that the Kildares just mentioned are few.

It also ignored the other end of the graph, that which is inhabited by the higher charging physicians, and the fact that they influence the prevailing range as well.

A fourth apprehension was that this mechanism might evolve into another fixed fee schedule, freezing you in the ice of a formula which does not permit change. The truth is that a doctor may request change in customary fee upon 90 days notice, citing as reasons any of many factors.

Action will be immediate. It should be kept in mind that even should this request fall outside the prevailing range at that time and be disallowed beyond the extreme of range, the factor of the request itself will tend to extend the prevailing range, in standard statistical method.

BUT THIS BRINGS us to a *fifth* concern, *and one I share.* It is that the very flexibility of the program could, without self control, result in such fee escalation as to bring us all in grave danger of control by others.

You may have noticed the warning of a former president of the American Medical Association, Dr. James Z. Appel, in an address at the Philadelphia Medical Association the other day. Dr. Appel, as quoted by United Press International, said that "The voluntary establishment of reasonable income ceilings is the only protection the profession has against governmental price controls." He added that doctors must pass on to the patients some of the savings resulting from increased productivity, *especially as the amount of free service diminishes.*

He concluded, and I quote, "Unless something of this sort is done, society might well withdraw this freedom we enjoy to set our own fees and charges."

Walter J. Zimmerman, M.D., remarks in a recent issue of the Oakland County Medical Society *Bulletin,* there is some fear that the Variable Fee Program — and I quote — "is just another fee schedule in disguise."

Doctor Zimmerman continues:

"It could be just that, if it turns out that the rate at which fees are escalated outruns Blue Shield's ability to take in subscription cash. "However — and I continue to quote — "However, the plan is calculated to remain sound if it encounters only the normal evolution of fees for professional service.

"In any event, it looks to this writer," Dr. Zimmerman concludes, "as though we have everything to gain and nothing to lose by lending Blue Shield our participation and cooperation at this time, first because the Plan needs us to sell the new program, and second, because the doctor who signs the participating agreement can get out again on short notice if he finds himself disenchanted with the way the plan works out in his case."

The notice period is 15 days.

WE AT BLUE SHIELD are exploring utilization review procedures, partially in this regard, in cooperation with the profession both in Michigan and other states, and we shall report conclusions when possible. I do believe this concern should be kept in mind.

May I quickly add that I believe your experience with Blue Shield in present review procedures, both in connection with this and in the matter of determination of reasonableness of fee mentioned a few minutes ago, has shown you that we at Michigan Blue Shield *have* and intend *to continue to cooperate* fully with the profession in such matters.

Even during the confusion of the early months of Medicare, Michigan Blue Shield questioned few claims. We sent less than one percent of those claims question to Society review committees. We resolved the rest ourselves.

In our regular business we routinely review random samples of claims, as you know. Last year, in 1967, we paid a total of more than six million claims, as I noted.

Gentlemen, of those millions, a total of 990 went to State Society review committee. In percentage, that is .016 percent. And that is quite a batting average.

As I have said, we do not intend to force doctors to spend their time shuffling paper. Your business is rendering medical care.

We at Blue Shield are convinced that the new program will work and will advance our common cause as none of us foresaw, even a few years ago. There is a necessary *if* in that conviction, of course. The *if* is the matter of doctor participation.

IF DOCTORS PARTICIPATE, we shall succeed. *If* they do not, *we are in grave and common danger* — both Blue Shield *and* private medicine.

I can well understand why many doctors did not wish to participate in the M-75 program as it became antiquated. It forced physicians into additional billing of higher income patients. You and we suffered patient resentment, even though their certificates contracted them to this exact procedure, and even though Blue Shield made every attempt to educate both individual and group subscribers in every way.

I have not mentioned per-case participation which, as you know, presently permits a physician to retain the right to charge a greater amount in such cases as he may choose, provided he gets agreement from his patient.

This is an arrangement we now allow under the program which we have extended into our new program at the request of the State Society's Council. I would not be speaking with candor, however, if I did not indicate some serious misgivings about this.

I am afraid it may successfully deter full participation and will be looked upon by those in our community whom we must also satisfy — those who pay the bill — as an indication that the medical profession is unwilling to be cooperative, is unwilling to even subject itself to the administrative jurisdiction of an organization in which it plays a major role — in fact, the significant policy-making role.

THERE ARE OBJECTIONS which we hear periodically which are more philosophical in tone.

Put simply, it comes from physicians who object to any association of any kind with the so-called third party. They see no basic difference between government and the private payers of the bill for their services, nor any difference between commercial insurance companies and Blue Shield.

They feel that somehow their best interests are served if they remain aloof and apart from the matter of medical economics and allow it to be settled in some fashion between their patient and whoever it is that is paying his bill.

Can this kind of unwillingness to work with the system work to anyone's advantage?

Realistically, who can object? There are adequate provisions for payment outside range for unusual circumstances and procedures.

In addition, the classic and once wise justification for charging the affluent enough money to permit you to fulfill your proud duty of caring for the poor no longer holds.

In your general range of practice, the new Blue Shield Plan pays full fee with no connection in any way with patient income. In your treatment of the elderly and the indigent under government programs, you are entitled to customary fee, and the early inequities in those programs are being overcome.

WHY NOT PARTICIPATE? As I hope I have indicated, I find it hard to come up with a reason not to, except for the philosophical one I mentioned, and while I can respect and understand that, I cannot agree.

Let us look at this matter of participation in a positive sense, in terms of why you *should* participate.

In a purely selfish view, if you participate you are paid directly by Blue Shield with a minimum of paper work and with no collection problem — with, in fact, no financial contact with patient, even when you decide unusual circumstance merits additional fee.

Consider non-participation from an impersonal point of view. I have no doubt that should non-participation be large there will be inevitable and rapid escalation of fees, for such is the nature of economic pressures no matter how high may be our resolves.

Should such escalation occur, and occur in the measure which I think quite possible and in the measure toward which some elements of our society look with eager anticipation, Michigan Blue Shield and Michigan private medicine will be in true danger of losng all control of our drive toward our common goals, as I mentioned earlier.

I become as annoyed as all of you at this repeated waving of the flag of socialized medicine before us at the drop of a Medicaid aspirin, but tired as we may be of the warnings, they are true.

THE DANGER IS REAL.

The boy who is crying wolf at us all is not imagining or joking.

There are wolves abroad.

Or should I say, *at home*. Abroad, in every na-

Continued on Page 530

AUTHOR

John C. McCabe is president of Michigan Blue Shield, Detroit.

Sustained circulatory, respirator
and cerebral stimulation for th

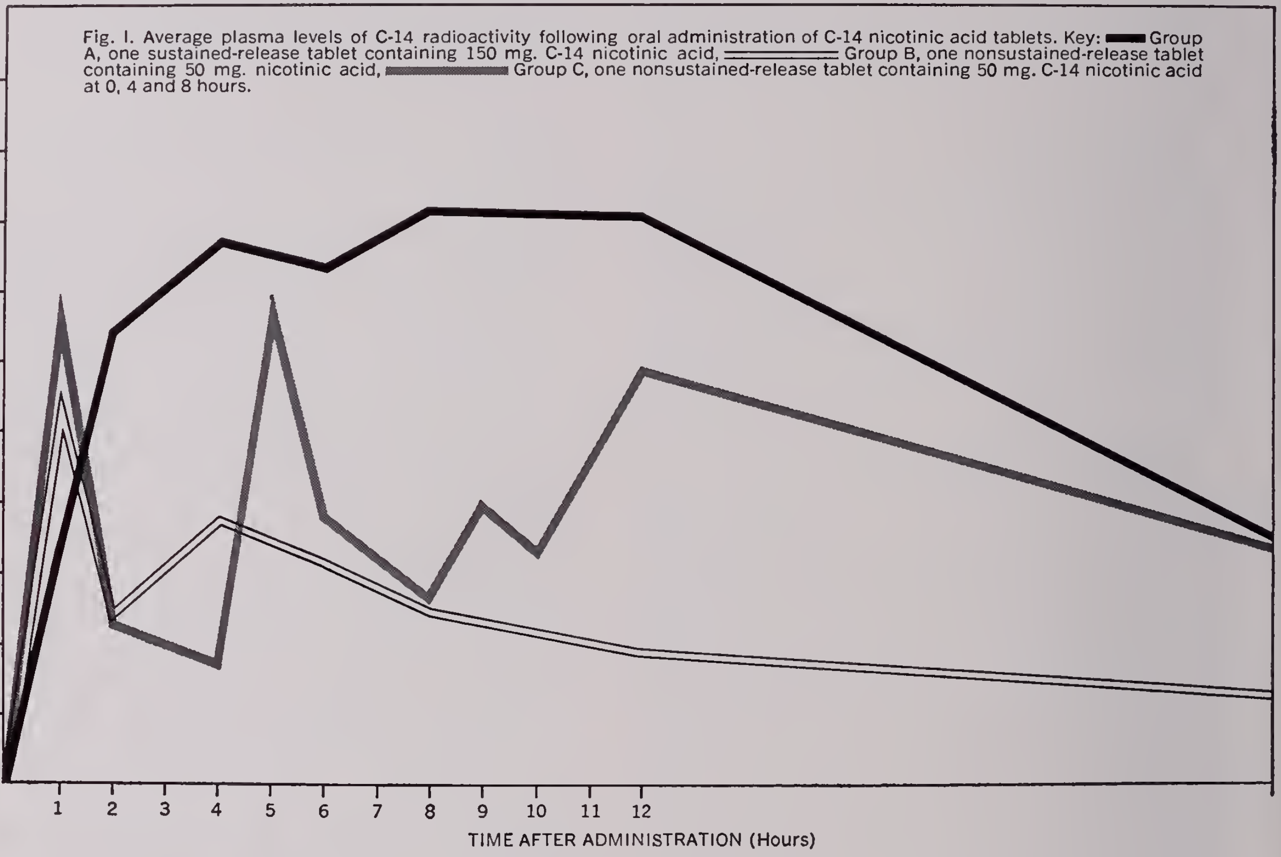

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

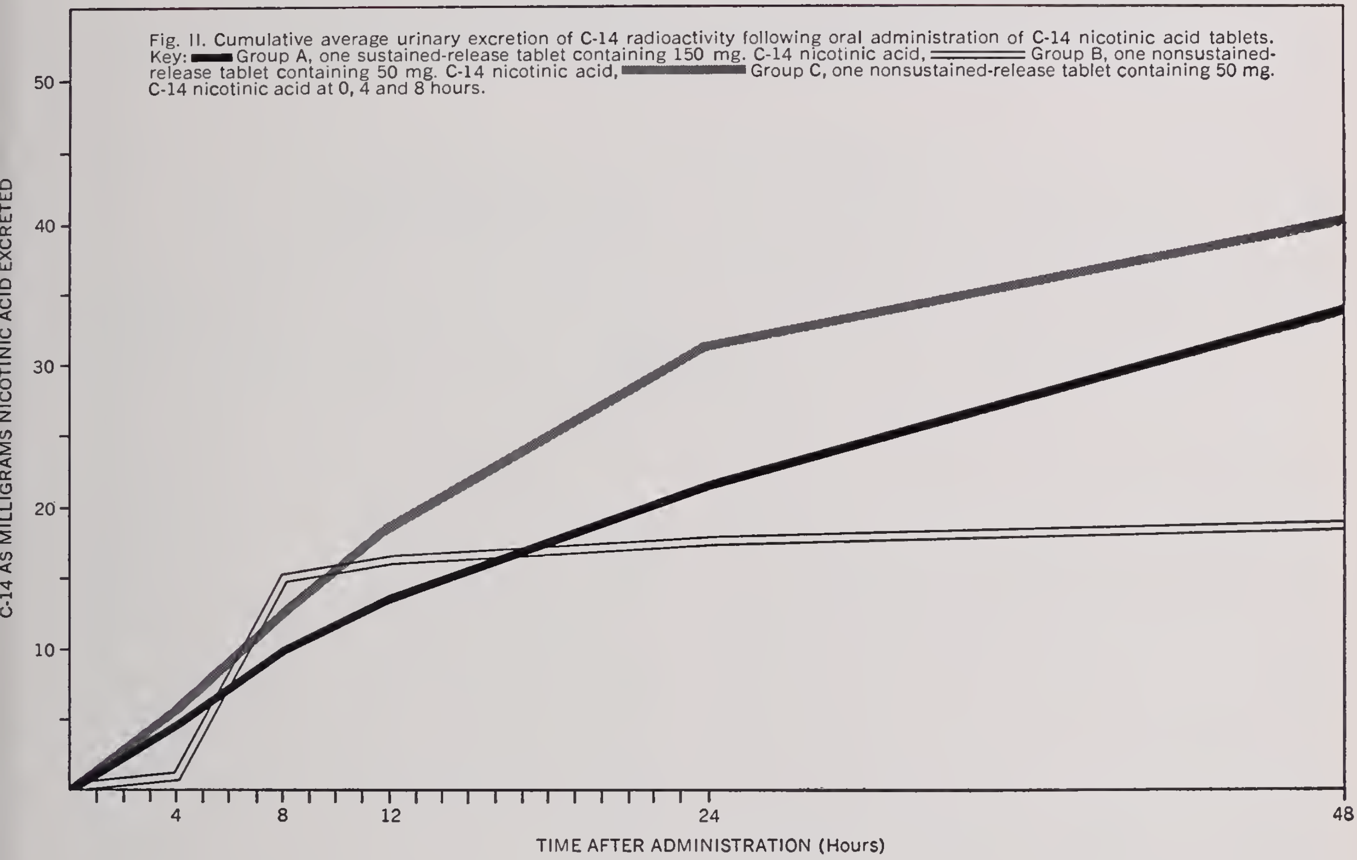

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

tion in Europe, the wolves took over some time ago.

I have discussed our common cause, about the goals that we should both have as targets. It seems to me that this can be crystallized very simply to provide a mechanism substantially which sustains and maintains the desirable elements of the private practice of medicine in such a way as to make available quality care at the lowest possible cost.

While that may sound like a trite statement of the type that indicates that I am for motherhood and against sin, please don't hear it that way.

It's that simple.

There are those who are convinced that a practical operational method is not obtainable. Certainly, if it is obtainable, it is going to occur through our structure and with your cooperation, as negative as that might seem as a raison détre for Blue Shield.

Blue Shield must be the answer.

THERE IS NO OTHER way that I can see.

Certainly, being against government or being against Blue Shield is not enough.

A positive policy must be put forth and I frankly think that none is more positive in the way of an available mechanism than Blue Shield.

As I see it, it is a simple question of working cooperatively and positively together in the development of the techniques needed to reach a common cause.

There are those who attack the efficiency of your care: there are many who cry thief and worse at the economics of that care.

I have been reading with interest the advertisements of some of our commercial competitors in the national magazines, in thinking of our own position as being one with medicine in common cause.

I note with wry gratification that more and more of these ads use Blue ink in their layouts, but I see them wandering farther and farther afield from all idea of service. Permit me to quote from one: This advertisement points out, in bold face italics, that payments under the policy, "go direct to you. Use the money for whatever you want, to pay back bills, to buy that vacation you owe yourself, or anything you desire." Then it says, "You do not have to give any of this money to a doctor or a hospital. It belongs to you."

True, this insurance is sold as a sickness income policy, but I do not think I need to go into its implications.

TO CONCLUDE, Blue Shield was created by physicians as a mechanism to serve the valid aspirations of both physicians and the public it serves. It has evolved according to these basic targets, sometimes falling behind, but always keeping to the original rules of service — as a structure operating without profit in the financial sense for the profit that comes as a result of the satisfaction for doing a job well. We have existed and continue to exist for you and the public, and the valid aspirations of each. Our cause is common, and it will continue to be.

In our view, our new program serves that common cause and merits your fully participating support. ☐

WORD WATCHING IS FUN IN MEDICAL JOURNALS . . .

Richard L. Reece, M.D., Hartford, Conn., gave an unusual address on "Does Humor Have a Place in Scientific Writing?" at the 1967 convention of the American Medical Writers Association. The following excerpt drew many smiles:

"Word watching is a good way of drawing fun-seeking readers into expository flow. At one time or another, most of us have poked fun at medical names or terms. It's safe, it's harmless, and it helps relieve frustrations over long, latinized words.

"To illustrate word watching, I have an article from the *Journal of the American Medical Association*. Its author, Doctor Howard H. Steel, an orthopedic surgeon, is wrestling with the problem of naming toe nail and fingernail lesions which resemble Garlic-Cloves. He has already discarded the term Steel's Nails because it lacks modesty, and he has rejected Hyperkeratotic Polypoid Ungual Fibroma as stark and inhumane. Here he is leading up to his final name—Garlic-Clove Fibroma.

"What is needed is a warm, homey sort of name. Numerous precedents exist for the use of a familiar descriptive term, a comparison with some household object . . . the silverfork deformity; the funnel breast; nutmeg liver; oat cell carcinoma; scalloped ribs; cauliflower ear; portwine stains; the doughnut pessary sage spleen; currant-jelly stool . . . coffee ground vomitus; and bringing up the rear, the grapes of wrath of the proctologist.

"The author's intent is clear. He wants to entertain his reader by playing on the shapes and sounds and meaning of names. Whatever his intent, I think he succeeds, for articles like his are likely to be read."

(The complete address by Doctor Reece appears in the November-December 1967 issue of the *American Medical Writers Association Bulletin*.)

Views Expressed on Recommendation Of State Crime Commission

Many physicians will want to study in detail the ramifications of a recommendation about the alcoholic made by the Michigan Commission on Crime, Delinquency and Criminal Administration. The following recommendation is quoted directly from the Commission's Digest of Recommendations:

Manage the Chronic Alcoholic Outside the Criminal Law

The Michigan Commission on Crime believes it is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code. But, for him who endangers himself, a new statute is called for to authorize civil protective custody of not more than 48 hours. We urge the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community.

Michigan Medicine invited members of the MSMS Committee on Alcohol and Drug Dependence to comment on one of the recent recommendations of the Governor's Commission on Crime, Delinquency and Criminal Administration. Comments are invited from all MSMS members for the Mailbag Department of the April issue.

The Commission recently presented the report of its year-long study, and offered 25 recommendations.

The first of the following letters to the Commission recommendation re "Manage the Chronic Alcoholic Outside the Criminal Law" is from the Chairman of the MSMS Committee on Alcohol and Drug Dependence, followed by other comments from Committee members:

HERBERT A. RASKINS, M.D.
DETROIT

May I speak wearing a multi-cornered hat: (1) Member of the Crime Commission; (2) Chairman, MSMS Committee on Alcohol and Drug Dependence; (3) Member, MSMS Committee on Mental Health; (4) Member, AMA Committee on Alcoholism and Drug Dependence; (5) Member, Detroit Mayor's Committee on Rehabilitation of Drug Addicts.

While it is true that the Crime Commission, so far, has made recommendations regarding the medical implications of caring for the alcohol dependent person, many other aspects of its function are going to also have consequential medical implications; viz., concept of criminal responsibility and its relations to psychiatry; civil commitment in lieu of prosecution and subsequent medical care programs for alcohol and drug dependent persons; medical care of sexual deviates who stand in violation of the law; probation and conditional discharges and medical-psychiatric care programs.

Obviously, each of these items becomes multiply subdivided.

OUR VARIOUS MSMS Committees must remain alert to each of them especially as the Legislature begins to consider the proposed revision of the Michigan Criminal Code.

The Michigan Commission on Crime, Criminal Administration and Juvenile Delinquency, among many other considerations, has spent much time reviewing the proposed criminal code revisions. The topic to which you make reference, "Manage the Chronic Alcoholic Outside the Criminal Law," relates directly to the proposed revision. It constitutes recognition by law, judiciary, law enforcement and, hopefully, legislature that the "chronic alcoholic," alcohol dependent person, is a sick person. His alcoholism is an illness and the person suffering from this illness is a responsibility of the physician and the entire medical profession coupled with the ancillary help of many of the other "care-providing" professions.

The entire aim of the recommendation of the Crime Commission is to provide the alcohol intoxicated and/or dependent person with the high quality of medical care to which he is as entitled as any other ill person. This implies the provision of adequate and total medical care.

In the position paper adopted by the Crime Commission at its meeting of December 15-16, 1967 was included the following statement:

"Chronic public intoxication is the disease of alcoholism in a most visible form. No cure of alcoholism will result from imprisonment for a violation of the public intoxication statute, but the proposed § 5545 and a civil 'detainer' statute will legitimate the police officer's taking the individual into custody. From that point forward, the relinquishing of heavy usage of alcohol is a matter between the individual himself and the resources of clinical medicine and community service which, acting in concert, would terminate the individual's dependence upon alcohol."

WE ALL CAN very quickly perceive the complete naivete of believing that the provision of detoxification shelters throughout the community constitutes the answer to the problem of alcoholism. It does, however, provide a very specific, medically supervised facility to which the law enforcement officer can turn when he encounters the acutely alcoholic person. Once the alcoholic is in the detoxification shelter he is no longer a police problem but now is a medical responsibility and it becomes a matter of medical decision as to what treatment programming then ensues. It can immediately deal with whatever medical or psychiatric, or both, emergency exists, effectuating disposition as clinically indicated.

What follows after this screening function in the provision of general medical, psychiatric and sociologic care now becomes the focus of Medicine and the community. How are we to determine exactly what are the needs of this particular person and what services exist within the community to provide for them? This also constitutes essentially a medical responsibility. Whether we view this as an administrative function of Public Health or Mental Health is really beside the point because both offices are going to be intimately involved in properly servicing the alcohol dependent person, the alcoholic.

Proper hospital care, medical and surgical and psychiatric must be provided; outpatient medical and psychiatric clinic facilities will be required; aftercare units to deal with all the various ramifications of social rehabilitation and utilization of the multitude of social agencies, governmental and voluntary, and community organizations will be essential to the proper medical care of this person. We as physicians have a vital role to play in this kind of treatment and care program.

On January 10, 1968 the MSMS Committee on Alcohol and Drug Dependence voted unanimously to accept and support the provisions of the proposed revision of the Michigan Criminal Code as it relates to problems of alcoholism. As per this date, MSMS Council has not acted on this recommendation. It is our aim to follow through on this recommendation toward the provision within the state of Michigan of adequate medical and rehabilitative facilities to meet with the individual and community problem of alcoholism.

DONALD L. DAMSTRA, M.D.
BRIGHTON

The recommendation sounds like the Michigan Crime Commission is grabbing a two-edged sword and better be very careful about how they grab hold of it. This recommendation certainly indicates that they are recognizing the need for medical treatment for intoxicated persons. I see no reason to suspect that the intoxicated persons needs any more or less medical treatment regardless of whether he has endangered himself, or has endangered someone else, and has been detained under the provisions of the criminal code.

IF SUCH A recommendation were to be adopted into law, it would seem to me that it would be encumbent upon all of the jails, who have occasion to hold people under the criminal code, to provide adequate medical treatment.

Providing for forty-eight hours of protective custody for the purpose of emergency detoxification would certainly be for many intoxicated persons better than no help at all. On the other hand, such a facility available generally would allow many seriously ill alcoholics to continue drinking, recognizing that any time they wanted to they could place themselves in protective custody for treatment. This type of treatment with such a limited scope certainly may not only be not helpful but actually hinder the recovery of a significant number of alcoholics. These are factors that would certainly need to be taken into consideration before such a change in the law could be enacted.

ANOTHER QUESTION which should certainly be asked is "Why is it necessary to establish small emergency detoxification shelters with medical facilities which is, for practical purposes, creating new medical facilities when such a function should much more logically be carried out in the local general hospitals?"

Creating new facilities for a specific and specialized medical problem is always a significantly more expensive proposition than mobilizing and utilizing existing medical facilites.

RICHARD C. BATES, M.D.
LANSING

The suggested change in the criminal code sounds great. I'm all for it.

CLAYTON K. STROUP, M.D.
FLINT

There are two parts to the report of the Michigan Commission on Crime. In the first part, they state "they believe that it is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code."

I BELIEVE THAT this is contrary to the opinion that alcoholism is a disease. However, we who believe alcoholism is a disease and should be treated as a disease are in a position in some cases to actually give a person who is an alcoholic a license to commit a crime. This can no more be accepted than a person with the diagnosis of kleptomania being given a license to steal. Therefore, people who become intoxicated and endanger others must have some sort of penalty attached to their misconduct, but in addition, if we are to be of any service in the prevention of further crime or further danger to other people, something must be done in the way of treatment of the alcoholic. Therefore, if the person who becomes intoxicated and endangers others is to be placed in some type of a security complex, there must be medical treatment to prevent the recurrence of their misconduct.

The second part of the report states, and I quote, "But for him who endangers himself, a new statute is called for to authorize civil protective custody of not more than 48 hours. We urge the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community."

AGAIN, I AM IN disagreement. I think that the day is coming when all hospitals must have an alcoholism treatment unit. It would be my hope that there would be a security area with intensive nursing care as needed for the severely ill alcoholic, but in addition to this, there should be a unit which might well be used by other ambulatory patients which might be called a self-service unit, one where the patient made his own bed, stood in line to get his meals, and did not require very much nursing care.

The second part of this requirement would be that each hospital would have an alcoholism treatment program. I feel that each hospital should have alcoholism therapists and consultants in the care of the alcoholic.

In some hospitals, this might be entirely within the structure of the hospital and the consultants be from the attending staff, but in others it might be conceivable that alcoholism therapists could organize in groups, either profit or nonprofit, in which they would lease their services in the treatment of alcoholics to the smaller hospitals.

THERE SHOULD ALSO be out-patient departments which the alcoholic should be required to attend. This should not be at the tax payer's expense. The alcoholic should pay his own way and the only distinction between the care of the alcoholic and patients with other diseases would be the mandatory therapy.

We in the medical profession have a "tiger by the tail." We have advocated the proposition that alcoholism is a disease and at this point we have been trying to find methods of care for the alcoholic. To date we do not have a cure. There have been too few hospitals which will admit the alcoholic patient and the refusal of the others to take care of alcoholics has put an unfair burden on these few hospitals. I believe the same thing might be said of physicians. There are too few physicians who will treat alcoholics and the refusal of the other practitioners to assume their responsibility has made an unfair burden on these few doctors.

C. FRED MOENCH, M.D., M.P.H.
MIDLAND

The Michigan Commission on Crime recommendation re "Manage the Chronic Alcoholic Outside the Criminal Code" as submitted in its Report to the Governor appears to have some serious medical implications as well as socio-economic involving the individual, the home, the community, and the tax dollar.

Having had considerable experience in dealing with the problems created by the alcoholic and his medical and socio-economic treatment, I agree with the Michigan Commission on Crime that it

Continued on Page 536

Weighing on his mind, too

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of childbearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories **Philadelphia, Pa.**

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, non-narcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

is appropriate to continue to apprehend and detain publicly intoxicated persons who endanger others, under provisions of the criminal code.

HOWEVER, FOR THE alcoholic who endangers himself, the new statute called for authorizing civil protective custody of not more than 48 hours and the recommendation for the establishment of small emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community, presents many complexities in terms of definition of alcoholism as a disease, protection of civil rights, methods and procedures for the apprehension of the alcoholic who endangers himself only, and techniques of enforcement. These are factors requiring careful consideration and thought before a new statute offering civil protective custody could be considered practical for enforcement.

In the first place, all intoxicated persons apprehended are not alcoholics in terms of our present definitions. An intoxicated person may be a social drinker who has misjudged his threshold of tolerance for alcohol. A true alcoholic is oftentimes a lone drinker who successfully conceals his illness from his family, his doctor, his minister, and his business associates for years. It is only when the eventual change in drinking pattern permits a diagnosis through physical, mental, and emotional signs and symptoms that we may suspect the person as being an alcoholic.

IF WE ASSUME that alcoholism is an illness it should be classified and subject to treatment as are diseases with signs and symptoms of cancer, diabetes, heart disease, tuberculosis, etc. The uncontrolled diabetic who refuses treatment endangers himself and might become a menace to the public while driving his automobile on the highway. The proposed new statute to provide protective custody and detoxification for the alcoholic raises a question of whether or not this kind of statute should not be broadened to include all illnesses.

Another question involves a definition of the intoxicated person who endangers only himself — it is doubtful whether such a person exists. In my experience an intoxicated person is either a potential or a direct hazard to others. Primarily, by direct physical injury; secondarily, through threats to the socio-economic security of others. Under the proposed new statute, who would be responsible for making these decisions?

IT IS MY FEELING that the proposed 48-hour civil protective custody order is far too short a time to accomplish emergency detoxification. Along with detoxification is the necessity for certain laboratory and X-ray examinations to establish an uncomplicated diagnosis of alcoholism or intoxication. Entirely absent in the proposed statute is any provision for education of the intoxicated or alcoholic person which is a most important factor in treatment. It is also possible that the 48-hour protective custody would encourage persons inclined to become intoxicated to abuse this civil type of treatment knowing full well that they would not be confined in jail. The protective custody order for emergency detoxification would require that 24-hour coverage from the prosecutor's office would be necessary to obtain the order. This has not proved too difficult in obtaining protective custody orders for alcoholics involved under criminal law. Some plan of procedure would have to be devised to deal with the chronic alcoholic outside the criminal law.

In a constructive vein, I do agree in principle that emergency detoxification shelters with suitable medical services to be administered by the public health or mental health programs of each community should be available. These services should be available to all alcoholics regardless of their status with aspects of criminal law. In fact, this type of treatment facility is a primary need throughout Michigan. I believe that treatment of the alcoholic must be provided in general hospitals of each community regardless of whether or not the suitable medical services are administered by the public health or mental health programs. I believe that the period of treatment must include education to the patient about alcohol and alcoholism and that the length of treatment should not be less than ten days to two weeks, with adequate follow-up supervision of patients through Alcoholics Anonymous, the public health department or the mental health program, once the patient is discharged from the hospital, and that careful attention be paid to the patient's need for habilitation and rehabilitation. I believe that the "team approach" utilizing local treatment resources and facilities is essential to obtain optimum results.

THE PROGRAM FOR treatment of the alcoholic, devised and administered by the State Board of Alcoholism as it was formerly known, but currently placed in the Michigan Department of Public Health, made a fine beginning with their limited resources in providing treatment for the alcoholic and progress has been made. I believe it is now timely to consider the initiation of treatment facilities in general hospitals, similar to that developed in St. Luke's Hospital in Saginaw.

I believe that the doctors of Michigan owe a debt of gratitude to the Michigan Commission on Crime for the splendid effort made by that commission in concentrating on the need for study and planning toward the objective of obtaining adequate treatment facilities and services for the chronic alcoholic.

HAROLD M. GAY, M.D.
COLEMAN

With the first statement it is difficult to see how anyone could disagree. It is basic to our form of government that that government shall protect our liberty from the licence of the few.

I also see no possible quarrel with the recommendation that a drunk should be protected from his own folly. Putting an inebriate under protective custody may very well save his life. Properly administered, and we cannot even discuss it unless we can assume that there would be responsible administration, this provision is really nothing more than enlightened Public Health.

AS USUAL THE CRUX of the whole matter rests not on what needs to be done or how it should be done or even on achieving a consensus which will provide that the thing shall be ordered done. The real hurdle it seems to me is assembling those things necessary to implement and to accomplish the goal before us.

Buildings are easy to get. So is equipment. Ancillary medical personnel are relatively easy to assemble.

BUT WHAT OF THE administrator? He should be a physician. In fact, in my opinion, such a clinic or "Shelter" will fail under anything but medical management. Just let one diabetic or stroke victim die in such a place unattended by a physician and the whole thing will collapse. Such management will be extremely difficult to attract. Such a physician will be handling drunks — alcoholic or otherwise — and the attitude of the average physician in private practice in relation to drunks is too well known to deserve or need further comment.

However, Russia, I understand, is doing something very similar to this, indeed better than this. Their program is aimed at final arrest of the disease in those who are determined to be alcoholics. What Russia can do certainly Americans can do too. This kind of program has been a serious need for thousands of years. In our highly organized, complex society it is no longer a need it is a must.

Even recognizing what at present seem to be almost impossible obstacles I none-the-less wholly agree with the Commission's report and recommendations.

JOSE J. LLINAS, M.D.
LANSING

I entirely agree with the philosophy implicit in the report.

The real problem, however, is whether our local communities and the people of the State are ready to assume the responsibility for this type of care.

It is stated policy of the Michigan State Department of Mental Health that no direct programs for alcoholics will be funded under Act 54 of 1963, (the Community Mental Health Services Act). This in fact precludes any cooperative arrangements between local hospitals and mental health boards for the development of detoxification centers and other appropriate services.

It seems clear to us that the legislature should act to decide who will have responsibility for these programs, and how they should be carried out and funded.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.

TUBERCULIN,TINE TEST
(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

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PUBLIC RELATIONS

MICHIGAN NEWSPAPERS COMMENT ON MEDICAL SCENE

A challenge to the medical profession to police itself effectively is presented in an editorial from the Muskegon *Chronicle*. Entitled, "A Few Bad Apples Are Spoiling Luster of the Doctor's License," the editorial discussed the operation of state board of registration in the nation. The closing paragraph declared:

"A medical license represents a high trust which the lay public is prone to respect. It behooves the profession to insure that the charlatans in their midst never destroy that faith."

The many western Michigan readers of the *Grand Rapids Press* recently read an editorial praising the Kent County Medical Society. The editorial rated a KCMS project as significant. The article lauded the project for "helping to provide Grand Rapids with more effective service from policemen, firemen and deputies."

The editorial, in part, declared:

"Working with recruits and in-service veterans who are interested, KCMS Project Chairman Mark Vasu's team of 10 physicians and surgeons trains policemen, firemen and deputies in proper emergency procedures and techniques.

"The medical project had its origin, explains Doctor Vasu, in the doctors' criticism of procedures used by policemen and firemen in emergencies. 'It finally,' he says, 'became a matter of why criticize why not help?' "

Grand Rapids Police Supt. William A. Johnson has praised the physicians for "giving so freely of themselves to make our police force a better instrument of community service."

The *St. Joseph Herald-Press* recently declared:

"There is something very special about a good doctor. In these days when so much emphasis is put on the common man and equality, the instinct of survival dictates that when we get sick, we want no part of the common man. We want an uncommonly good doctor and good doctors are not created overnight.

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
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7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Methyl Testosterone	2.5 mg.
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Methyl Testosterone	5.0 mg.
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Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available: Bottles of 100, 500, 1000.

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Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available: Bottles of 60, 500.

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WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN
Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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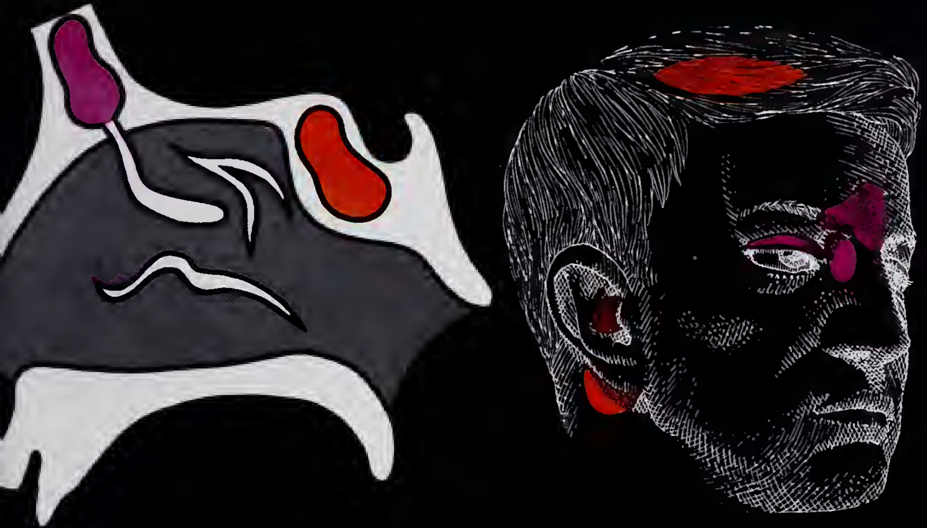
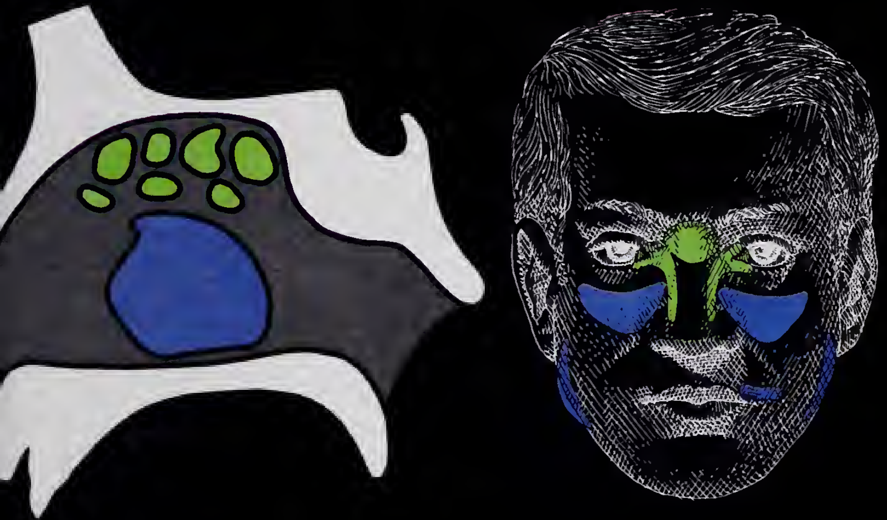
Sources of sinus headache



REGION OF SENSATION

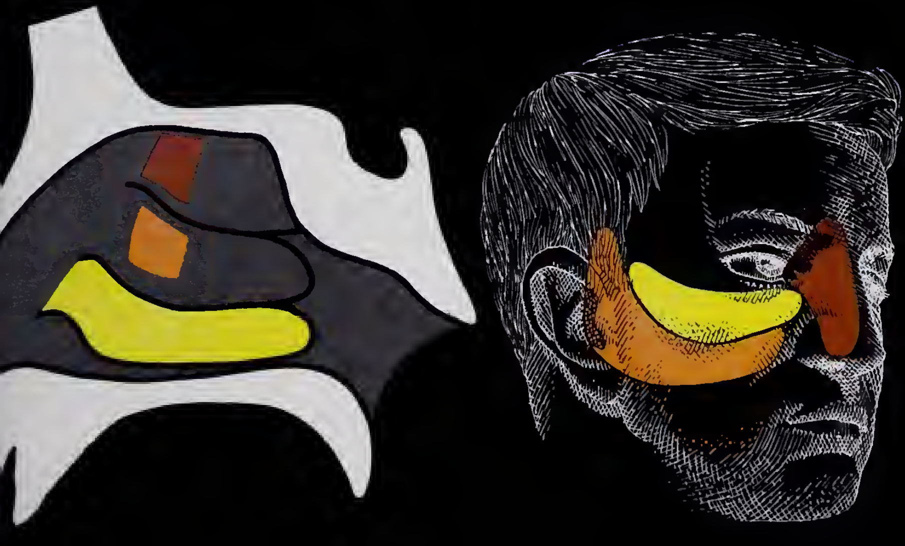
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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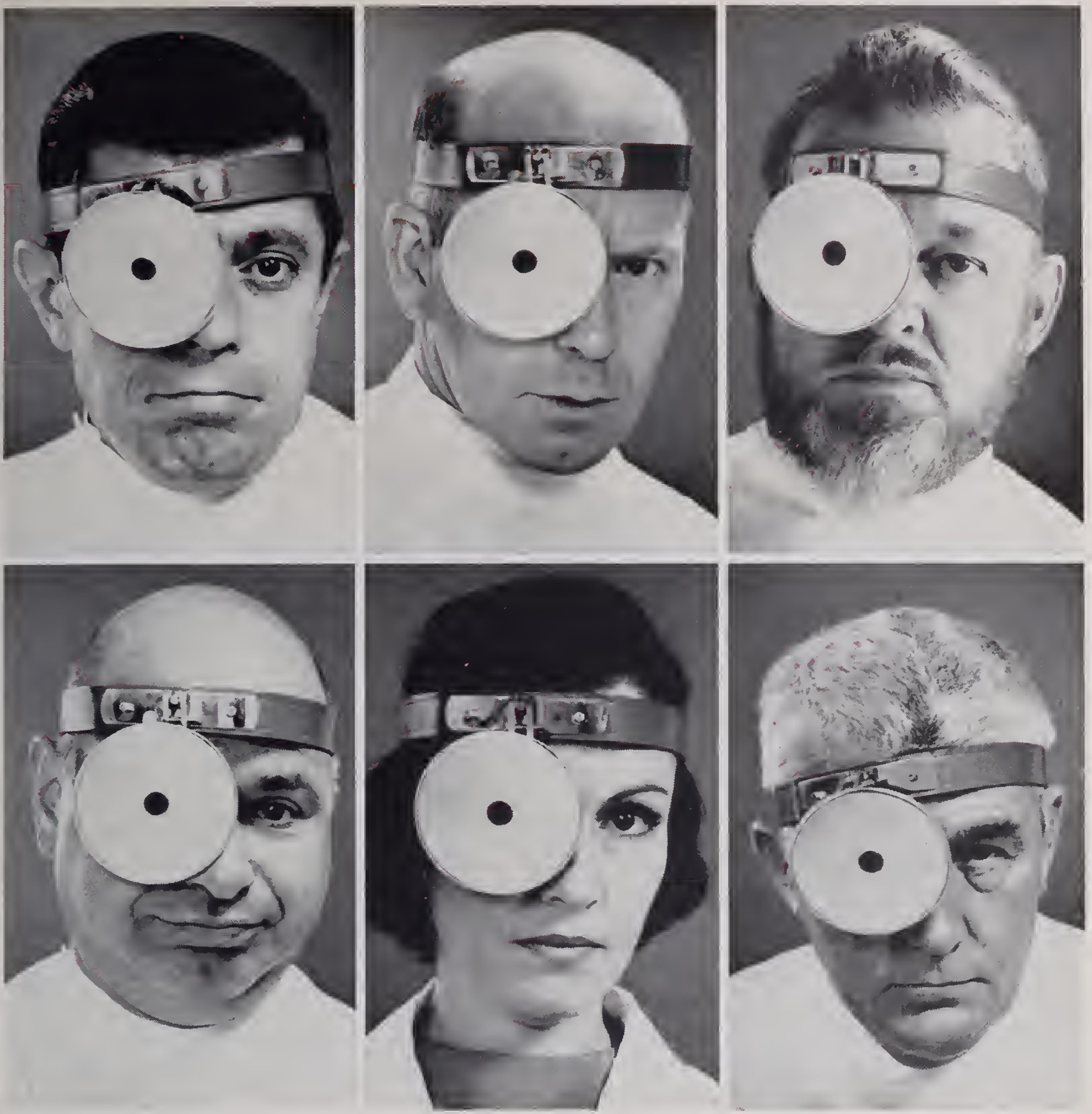

"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Arsenio B. Ablao, M.D., Northville State Hospital, Northville, 48167

John E. Boudeman, M.D., St. Joseph Mercy Hosp., Ann Arbor, 48104

Carter D. Brooks, M.D., Upjohn Company, Kalamazoo, 49001

Jerome E. Feldstein, M.D., 3601 West 13 Mile Road, Royal Oak, 48072

Donald V. Jablonski, M.D., Detroit General Hospital, Detroit, 48226

Allan M. Katz, M.D., 461 West Huron St., Pontiac General Hospital, Pontiac, 48053

Charles T. Kelso, M.D., 18371 North Shore Estates, Spring Lake, 49456

Bernard M. McGibbon, M.D., 900 Woodward Ave., St. Joseph Mercy Hosp., Pontiac, 48053

Carl Morton, M.D., 3601 West 13 Mile Road, Wm. Beaumont Hosp., Royal Oak, 48072

Ervin Novak, M.D., Upjohn Company, Kalamazoo, 49001

Paul B. Simmons, M.D., 461 West Huron St., Pontiac General Hosp., Pontiac, 48053

John C. Wells, Jr., M.D., 1220 Lakeshore Drive, Muskegon, 49441

Fredk. M. Adams, M.D., 800 S. Adams, Birmingham 48011

Manoochehr, Agah, M.D., 1151 Taylor, Detroit 48202

Severo R. Armada, Jr., M.D., 32900 Five Mile Road, Livonia 48154

Manou C. Atash, M.D., 1728 Grant, Birmingham 48009

Lutfi Y. Bayazit, M.D., Mt. Pleasant State Home, Mt. Pleasant 48858

Rajendra Kumar Bhama, M.D.. Ypsilanti State Hosp., Ypsilanti 48197

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Robert H. Brougher, M.D., 1100 West Huron St., Ann Arbor 48103

James F. Clark, M.D., 201 Lafayette Ave., S.E., Grand Rapids 49503

Gerald F. Conway, M.D., 938 David Whitney Bldg., Detroit 48226

Edward F. Crippen, M.D., 316 City-County Bldg., Detroit 48226

Pedro Ruiz DeCastilla, M.D., 424 Quincy Street, Hancock 49930

Harvey M. Gendler, M.D., 269 Northland Drive, Rockford 49341

Phillip A. Hoskins, M.D., St. Joseph Mercy Hosp., Ann Arbor 48104

Robert H. Moyad, M.D., 303 Pearl Street, Ypsilanti 48197

Satya Paul Pasricha, M.D., Ypsilanti State Hospital, Ypsilanti 48197

Cornelis Van Nuis, M.D., 245 State Street, S.E., Grand Rapids 49502

Robert Wylin, M.D., Harper Hospital, Detroit 48201

James W. Sharpe, M.D., 310 E. Water St., Port Huron 48060

Arthur R. Basel, M.D., 901 Crescent, Midland 48640

B. B. Kumar, M.D., Mt. Pleasant State Home, Mt. Pleasant 48858

Antimo Candell, M.D., 2318 Medford, Ann Arbor 48104

James E. Baker, M.D., VA Hospital, Battle Creek 49016

Wm. Henderson, D.O., 320 W. Superior St., Alma 48801

Alan L. Keaton, M.D., 2410 Walter Drive, Ann Arbor 48103

Norman N. Komar, M.D., 1605 Argyle Crescent, Ann Arbor 48103

Robert R. Ross, M.D., Detroit General Hospital, Detroit 48226

Gary S. Sandall, M.D., 611 Church Street, Ann Arbor 48104

Lyall C. Stilp, II, M.D., 1525 Marion, Ann Arbor 48103

Earl E. Sunderhause, M.D., 1086 Island Drive, Ann Arbor 48104

MANY REPRINTS ORDERED

Pfizer Company ordered 100,000 reprints of an article by Doctors Peter Barlow and John H. Burger on "A Combined Drug for Asthmatic Symptoms," which appeared in the October, 1967 issue of *Michigan Medicine.*

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MAILBAG

I want to thank you for the excellent January issue of the *Michigan Medicine*. We are all extremely pleased that you dedicated this to Wayne State University on the occasion of its 100th Anniversary celebration.

Your articles were all good, interesting; and I thought the format of the entire presentation was one of the best that I have ever seen. Again, thanks to you and the State Society for this recognition.

Gordon H. Scott, Vice President
for Medical School Development
Wayne State University

Congratulations on the excellent feature in the February issue of *Michigan Medicine,* spotlighting the work of the Michigan physicians who have worked among the civilians of South Vietnam.

This past year, the International Health Committee of the Michigan State Medical Society took a survey of all county medical societies to ascertain how many physicians had served overseas in various programs. The total is well over 80 doctors. Many of these men have gone several times to the same country or different countries such as Doctors Alfred Swanson, John Rawlings, and myself.

I feel that the article and attractive cover, expressed the MSMS and AMA appreciation to all the Michigan men who have served overseas.

On behalf of the International Health Committee of MSMS I would like to commend those physicians.

Medicine speaks the international language of people and there is a tremendous medical need in all the developing countries. The physician who works overseas will use every ounce of energy and medical skill which he possesses to help people who desperately need him. The demands are rigorous, the appreciation of the people is real and heartfelt, and the satisfaction of the physician is genuine.

I hope the Vietnam feature will encourage other Michigan physicians to consider the possibility of some kind of overseas service. There are a wide variety of overseas programs which will sponsor a doctor who wants to work overseas, depending on

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the country in which he wants to work, length of stay, and the kind of work he would like to do.

Information on these programs can be obtained from the International Health Committee, P.O. Box 152, East Lansing 48823.

It would be appreciated if anyone knowing doctors who have served (and plan to serve) to please write in and let us know the name, date, and countries that they have served in and whether it was a missionary hospital, AMA program, clinical program, orthopedic overseas program, Project Hope, or other type of program. This will help us keep aware of what Michigan doctors are doing in the international field.

Hira E. Branch, M.D.
Chairman, International Health Committee

On behalf of the Wayne State University Centennial Commission I would like to commend you on the outstanding January issue of *Michigan Medicine* saluting the University's 100th year.

The issue has brought many favorable comments from both faculty and administrators at the University. We are pleased and proud to have been so well represented in such a highly regarded professional publication.

We at the University are hopeful that you and your reader audience will be able to join us in the many events planned during Wayne State's Centennial Year Observance.

Sincerely,
George E. Gullen, Jr.
Vice President
University Relations
Co-chairman Centennial Commission

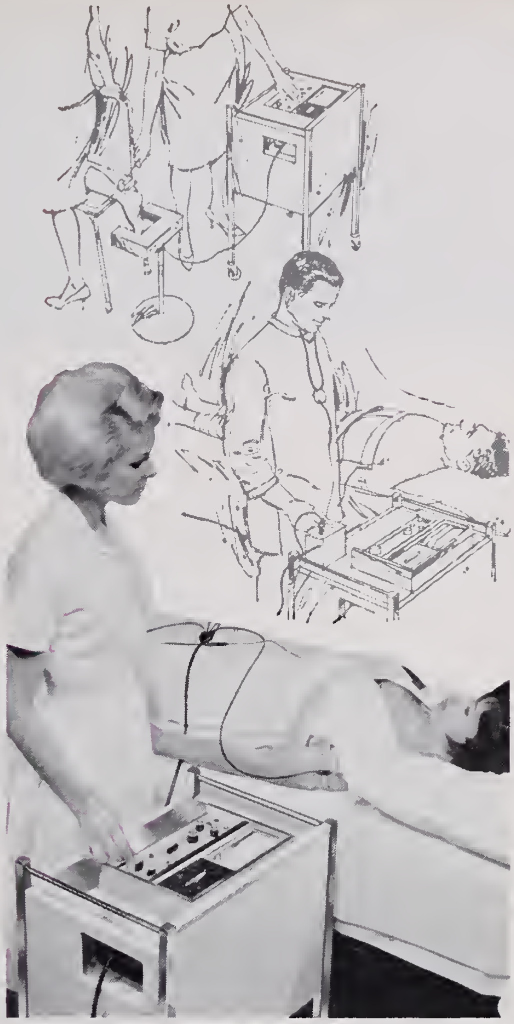
Congratulations! The January 1968 issue of *Michigan Medicine* is superb.

The photographs and art work add a great deal to the text. I like especially the picture of the old St. Mary's Hospital surgical amphitheatre. This was the center of clinical teaching and was an important factor in the renaissance of medical knowledge in Detroit in the 1880s.

I know the effort and work which goes into the production of a special issue of the State Journal and I wish to thank you and your associates.

As a member of the Wayne State University Centennial Commission I express the gratitude of the University for the special volume which will remind doctors throughout the State that Wayne is a state University which is training more students of Michigan than any other university.

Alfred H. Whittaker, M.D.
Detroit, Trustee,
W.S.U. Board of Governors



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IN MEMORIAM

I. W. Brown, M.D., Kalamazoo

Irmel W. Brown, M.D., a former director of the Kalamazoo Public Health and Welfare Department, died February 17. He was 73.

After receiving his B.A. from Albion College, he worked with Dow Chemical Company in Midland and in 1919 was appointed to the chemistry faculty at Albion College. He was graduated from the University of Michigan Medical School in 1925 and served his internship at St. Mary's Hospital in Grand Rapids in 1925-26.

Doctor Brown began practice in Marion and in 1928, he moved to Kalamazoo where he served as the city's health and welfare director from 1936 to 1942. Returning to private practice, he was on the medical and teaching staffs of Bronson and Borgess hospitals. He headed the Department of General Practice at Borgess in 1955.

He was a Life Member of the Michigan State Medical Society and a member of the International Society of Medical Health Officers and the American Public Health Association.

H. E. Carnes, M.D., Detroit

Harry E. Carnes, M.D., Detroit, died January 28. He was 59.

Born at Alabama City, Alabama, he attended Emory University, Atlanta, Georgia, and was graduated from the Emory University School of Medicine in 1939.

His internship was done at Ford Hospital from 1939-40. Shortly afterwards, he joined Parke, Davis and Company, where he did clinical investigation and industrial research for many years. He also served as editor of the Parke-Davis publication *Therapeutic Notes*. He held a teaching appointment as clinical instructor, Department of Medicine, Baylor University, Houston, Texas.

During World War II, Doctor Carnes served in the U.S. Army Medical Corps, 8th Medical Laboratory, in Australia, New Guinea and the Dutch Indies, attaining the rank of Lieutenant-Colonel.

He was a member of the American Society of Clinical Pathologists, the Federal Society for Clinical Research, and Theta Kappa Psi.

C. D. Eaton, M.D., Detroit

Crosby D. Eaton, M.D., Detroit internist, died January 27 at the age of 72.

He received the B.S. degree from Kalamazoo College and was graduated from the University of Michigan School of Medicine in 1922. After his internship at Grace Hospital in 1922-23, he began practice in Detroit, specializing in internal medicine and endocrinology.

Doctor Eaton was a Life Member of the Michigan State Medical Society and a member of the Michigan Diabetes Association and the American Diabetes Association. He was a member of the Detroit Boat Club.

Dwight Goodrich, M.D., Traverse City

Dwight Goodrich, M.D., retired Traverse City physician, died January 21 at the age of 83.

Doctor Goodrich was a past president of the Grand Traverse-Leelanau-Benzie County Medical Society.

Doctor Goodrich, born in Belize (British Honduras), was a graduate of Ann Arbor High School, Ferris State College and Wayne State University Medical School, class of 1917.

He began practice at Flint where he was a member of staff at Hurley Hospital. He received four years of postgraduate training in urology there. From 1932 until his retirement, he maintained a general practice in Traverse City where he was affiliated with the Munson Medical Center.

William Klein, M.D., Detroit

William Klein, M.D., Detroit general practitioner, died December 9 at the age of 65.

Born in Rumania, Doctor Klein received his premedical education at Northwestern University. He was graduated from the Detroit College of Medicine and Surgery in 1933. He served his internship at William J. Seymour Hospital, Eloise, and did postgraduate work at the Chicago Maternity Center.

In 1934, Doctor Klein began general practice in Detroit, affiliating with Brent General Hospital. He was Director of Villa Zion Geriatric Hospital in 1958.

He was a member of the Maimonides Society and American Geriatric Society.

Charles T. Lewis, M.D., Detroit

Charles T. Lewis, M.D., Detroit physician since 1920, died January 2 at the age of 75.

Doctor Lewis, born in Ontario, Canada, received his M.D. degree from the University of Toronto School of Medicine in 1916. During World War I he served as a Captain in the Canadian Army Medical Corps and was decorated with the Military Cross. He then served his internship at Harper Hospital and residency at Children's and Herman Kiefer Hospitals in Detroit and established his practice there.

He was a Life Member of the Michigan State Medical Society.

C. K. Stulik, M.D., Union Pier

Charles K. Stulik, M.D., Union Pier, emeritus associate clinical professor of pediatrics of the University of Illinois Medical School, died February 1. He was 78.

Doctor Stulik, who received his B.S. degree from the University of Chicago, earned degrees in pharmacy and pharmaceutical chemistry from the University of Illinois before entering medical school. He was graduated from Rush Medical College in 1916 and served in the U.S. Army Medical Corps during World War I.

In many years of practice in Chicago, he taught pediatrics at Rush Medical College, served as supervisor of infant welfare of Chicago for 25 years, was attending physician in pediatrics at Cook County Hospital for 22 years and consulting physician to many other hospitals and orphanages.

After moving to Union Pier 15 years ago, Doctor Stulik continued his practice of pediatrics and also served as deputy medical examiner of Berrien County.

Doctor Stulik was a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics and the Institute of Medicine. He was also a member of the Illinois Society of Medical Research and a Life Member of MSMS.

A collector of bells and antiques, he was a Life Member of the Art Institute of Chicago and an Associate Life Member of the Chicago Museum.

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SOCIO-ECON

SAYS MICHIGAN LAGGING IN SUPPORT OF HIGHER EDUCATION

BY ELMER WHITE,
EXECUTIVE SECRETARY,
MICHIGAN PRESS ASSOCIATION

Support for higher education is falling far behind other states a U-M study shows. Michigan appropriations to colleges and universities compared with appropriations of other states indicate a steady decline in this state's position since 1959.

On a per-capita basis, Michigan ranked 9th in 1959 with an expenditure of $12.33. In 1967 it ranked 17th. Appropriations per $1,000 of personal income put Michigan in 19th place in 1959. The state dropped to 27th place in 1967. Per-student appropriations in 1959 showed Michigan in 14th position. In 1967 it ranked 34th.

Taking all states into consideration, the average percent increase to higher education amounts to 214% since 1959; Michigan shows an increase of 142%.

* * *

Effects of not keeping up with increased costs is evident in rising tuition. Since 1959 enrollment has increased 126.5%, prices, salaries and wages have increased 48.3% and total operating costs have gone up 235.9%.

Michigan apparently is placing much less emphasis on aid to higher education than is the case in other states. ☐

MSMS Urges Editors Help Fight Quackery

MSMS placed an ad on the back cover of the 104-page Centennial issue of *Michigan Publisher,* the journal of the Michigan Press Association.

Copy described MSMS concern about quackery and urged editors to join MSMS in protecting the public health.

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Coffee Table Medicine

BY WALTER C. BORNEMEIER, M.D.
SPEAKER, AMA HOUSE OF DELEGATES

Statements are occassionally made, particularly in newspapers or magazines, that medicine is run by a hierarchy. Nothing could be farther from the truth.

Almost every doctor works at least part time to support some medical organization. The 200,000 physicians of the United States have a tremendous organization. This organization, however, starts at the grass-roots level.

THE COUNTY SOCIETY is the most important, for the county society is the crystallization of the ideas that start at the hospital coffee table. Almost every one who is active at the county level sits in on hospital staff, hospital doctor's room, and coffee table sessions. Certainly all actively participating state society people are the same people who are active in the county societies.

It follows then that the men who make the policy decisions at AMA level are the same individuals who are active at state level, county level and coffee table level.

The House of Delegates of the AMA is as grass roots as a town meeting. Its members are the fellows who practice medicine fifty weeks of the year and attend the AMA meeting the other two weeks. These practicing physicians make the policy. All new proposals are placed before reference committees for open hearings. There, any member of the AMA can discuss the proposals. Voting is limited to House of Delegates members.

A DOCTOR'S ATTENDANCE record at his local society meeting is not a true index of the man's interest in organized medicine.

Also, it is not an index of his scientific interest.

WHAT THEN IS A measure of the interest or support that the doctor gives to a unified profession? Among the many physicians who have contributed much to the health and welfare of the nation are individuals who seldom attend local society meetings. Some participate not at all.

It is difficult to find a common demoninator of interest. Certainly those doctors who attend their county or branch society meeting and work on committees have demonstrated concrete evidence of support. What about the man who never having attended a meeting of his local society is found suddenly to be the important officer in the society of internal medicine, or president of a foreign language medical group, or president of his hospital staff, or nominated for appointment to the AMA Council on Drugs?

Are not these people also giving their time and talent to create a better image of the profession?

Certainly we need a healthy nucleus of interested people to carry on the business affairs of our organizations, but most important we need all the rest of the members to support our organizations financially and be depended upon to swing into action if, as, and when they are needed. These non-attenders frequently pretend to be disinterested, yet they pay dues and provide the broad base from which the American Medical Association operates. These non-attenders are the reserves.

All of us together are Organized Medicine.

The ideas expressed at the Coffee Table may be the subject of a resolution at the next meeting of the AMA House of Delegates. With a broad base such as this, organized medicine can remain strong and can continue to serve the public in a manner befitting a noble profession. ☐

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Progress by Legislature Reported On Bills of Interest to Physicians

BY M. A. RILEY
MSMS LEGISLATIVE COUNSEL

This *News Extra* issue of *Michigan Medicine* reports to the MSMS members some of the major deliberations of the Michigan legislature.

"OPEN-STAFF" SUBSTITUTE BILL FAILS IN HOUSE

In an 11th-hour action, the House of Representatives on April 12 rejected Substitute HB 3707 ("Open-staff"). The vote was 48 for, 50 against and 12 abstaining or absent; with 56 required for passage.

* * *

PHARMACY BILL SET ASIDE BY SENATE

Senate Bill No. 1181, which would have added a number of expanded definitions to the Michigan Pharmacy Act and, through a proposed new section, would have made it impossible for a physician's aides to make more than a single dose of a medication available to a patient, has been rejected by the Senate.

The bill would have defined "dispensing" as the giving of more than one dose of medication, or the giving of even one dose "for subsequent administration." Since a distinction is made between the terms "dispensing" and "administering," the bill would have made it a violation of law for a physician to leave explicit instructions with an office aide to give any medication to any patient — iron to an expectant mother, for example.

An analysis of the bill showed that its provisions could not have any other than a serious and adverse effect on medical practice, particularly the practice of medicine in smaller communities by solo practitioners.

MSMS requested an amendment which would have made it clear that physicians could delegate and direct appropriate persons to supply medications and devices, but such an amendment was not acceptable to the bill sponsor. As a result, the Senate returned the bill to the committee from which it had come.

* * *

CHIROPRACTORS DENIED BLUE SHIELD RECOGNITION EQUAL TO MDs

On March 22 the State Senate Corporations Committee considered, and sent to the Senate "without recommendation," Senate Bill 1148 which, if passed, would have entitled chiropractors to register with Blue Shield, and have entitled Blue Shield subscribers to "definite medical care and surgical care, appliances and supplies by chiropractors in their offices, in hospitals and in the home." Since the Corporations Committee did not recommend passage of the bill it was "laid on the table" and kept alive where it could be considered if a majority of the Senate (20 members) wished to bring it up.

The effort was made to remove the bill from the table — and fell short of sufficient support. SB 1148 is thus "dead" for 1968. Similar bills have been introduced in past years and also failed.

(*Continued on 560*)

CONTINUED:

Report of Legislative Action in Lansing

HOSPITAL LICENSING LAW ENACTED

Michigan has adopted its first all-inclusive hospital licensing law. Signed by the Governor on April 5, Senate Bill No. 16 now becomes Public Act No. 17 of 1968.

SB 16, which was introduced last year under the primary sponsorship of the Michigan Hospital Association, was endorsed and supported by MSMS and many other public and private groups. Whereas formerly only institutions caring for social welfare or maternity cases were required to meet certain standards, now every hospital must meet basic criteria.

A 12-member State Health Facilities Council will be appointed by the Governor and this Council must concur in standards, rules and regulations for the maintenance and operations of hospitals as developed by the Director of the Department of Public Health. A clause of the new law states: "The Director shall not regulate the medical or surgical treatment provided a patient in a hospital by licensed medical personnel." Historic relationships between the governing bodies and medical staffs of hospitals and the authority and responsibility of each have been better defined but not basically altered.

Hospitals will pay a licensing fee based on $2 per bed with a minimum of $50 and a maximum of $500.

* * *

BILL TO DOUBLE ANNUAL LICENSE RENEWAL FEE SHELVED FOR 1968

A pair of bills (House Bill 3952 and Senate Bill 704), which would have doubled the annual license renewal fees for practically all licensed professions and occupations, has failed to meet the deadlines for action in the current session.

The increased funds proposed to be obtained by the bills would have gone into general funds without any specific provision for allocating them for purposes of the boards responsible for the professions and occupations. MSMS, pointing out that the annual renewal fees were first ostensibly established to obtain revenue for the boards involved, had not looked favorably on HB 3952 and SB 704.

* * *

ALCOHOLISM PROGRAM DEVELOPMENT BILL PASSES LEGISLATURE

Heavily supported by MSMS, House Bill 2961, which redefines the state's alcoholism rehabilitation program within the Department of Public Health, has received the approval of both the House and Senate. This bill removes the statutory reference to the program from the Michigan Liquor Law and expands the alcoholism advisory council from 5 to 7 members appointed by the Governor, besides better defining the scope of the program.

Concurrently, and also at MSMS' urging, the Senate has passed and sent to the House, where it must be acted upon before May 10, Senate Bill 336 which, if passed, will permit appropriations for alcoholism programs of double the size now allowed under the law. Five percent of the liquor license fees are now devoted to the program; under SB 336, ten percent would be the maximum appropriation.

Support for passage of SB 336 should be directed to State Representative Don Pears, Chairman of the House Liquor Control Committee, c/o State Capitol Building, Lansing.

* * *

ABORTION, GENERIC EQUIVALENT, AND LAY BOARD MEMBER BILLS FAIL

Bills retained by appropriate committees and thus no longer eligible for passage in 1968 include Senate Bill 568, to liberalize the statutes regarding therapeutic abortion, several proposals which if passed would have permitted pharmacists to substitute generic equivalent preparations for drugs prescribed by physicians, and a pair of bills (Senate 1003 and House 3659) which would have required the Governor to appoint a lay member to the Board of Registration in Medicine.

The generic equivalent bills have been introduced in previous sessions without success; some form of bill dealing with therapeutic abortion will no doubt be reintroduced in 1969. The lay board member concept, which was proposed for the first time this year, was opposed by practically all professional and occupational groups.

* * *

SEVERAL MSMS—ENDORSED BILLS ELIGIBLE FOR PASSAGE BY MAY 24

Senate Bills which have passed the Senate, and House bills endorsed by the House, have been referred to study committees in the other body and may be reported for final action up until May 10.

Once reported they must be passed, or rejected, by May 24.

Still very much under consideration and strongly supported by MSMS are Senate Bill 229, to repeal the Basic Science Law (presently before the House State Affairs Committee, Rep. Thomas Sharpe, Chairman); House Bill 2378, to establish a licensing procedure for clinical laboratories (before the Senate Health, Social Services and Retirement Committee, Sen. Lorraine Beebe, Chairman); House Bill 3946, to license ambulances and permit counties to contract for ambulance services (before the Senate State Affairs Committee, Sen. Thomas Schweigert, Chairman); Senate Bill 897, to eliminate the requirement that a reporting physician physically examine a "battered child" (before the House Social Services and Corrections Committee, Rep. Joe Kolderman, Chairman); and a pair of Senate Bills, 925 and 416, which make possible a better program of family life (sex) education in the schools, both of which are now in the House Education Committee, Rep. Clifford Smart, Chairman.

James E. Harryman, M.D., second from left, of Muskegon, chairman of the MSMS Maternal Health Committee, makes a point to Tommy N. Evans, M.D., right, banquet speaker, during the 1968 MSMS Maternal Welfare Conference held in Flint recently, while (left to right) Jack W. Thompson, M.D., of Flint, chairman of the conference, George F. Whyel, of Flint, a director of the Clara Elizabeth Fund in Flint which co-sponsored the conference, and Bradley M. Harris, M.D., MSMS president, listens. See details in May issue.

HEALTH PLANNING AMONG TOPICS FOR AMA CONCLAVE

Four general scientific meetings of wide medical interest will be included in the Scientific Program of the American Medical Association's 117th Annual Convention to be held in San Francisco June 16-20.

The four general sessions will focus on Automobile Accidents, Health Care Planning, Management of Infectious Diseases, and Treatment of Advanced Malignant Disease.

Regular scientific programs also will be presented by each of the 22 Scientific Sections.

The entire scientific program will appear in the May 6 issue of *JAMA*.

UP Society To Offer Experts From Wisconsin

Four speakers from Wisconsin will be among the headliners at the Upper Peninsula Medical Society's 75th Annual Meeting at the Four Seasons Club in Pembine, Wisconsin, June 21 and 22. The program lists Ernest M. Henschel, M.D., professor of anesthesiology, Marquette School of Medicine; Ralph L. Suechting, M.D., a neurosurgeon from Neenah; Ovid O. Meyer, M.D., professor of medicine at the University of Wisconsin; and James Nellen, M.D., orthopedic surgeon with the Green Bay Packers.

Other conference details will be reported later.

Current president of the UP Society is William S. Jones, M.D., from Menominee. L. Grant Glickman, M.D., also from Menominee, serves as secretary.

'68 Community Health Week To Focus on Drugs, Careers, Fitness

"Now is the time . . ."

"That's an old saw, but a true one," says Brock E. Brush, M.D., MSMS PR Committee Chairman, as he urges component societies to begin plans now for 1968 Community Health Week.

The AMA reports that the special 1968 Week, October 20-26, will focus on three subjects, "The Use and Abuse of Drugs," "Health Careers," and "Physical Fitness." The AMA packets soon will be available from the MSMS headquarters.

William J. Stapleton, M.D., left, spoke briefly at the recent banquet honoring WSU School of Medicine on its Centennial Anniversary. The banquet was sponsored by the Wayne County Medical Society. A highlight of the program was a donation by the Wayne County Medical Society and Wayne County Health Foundation for the Doctor William J. Stapleton Reading Room which will be part of the new medical library at WSU. Donald N. Sweeny, Jr., M.D., at right, presented the check. Doctor Stapleton, MSMS Historian, is dean emeritus of the WSU medical school.

McColl to Be Honored At WSU Alumni Reunion

Duncan J. McColl, M.D., of Port Huron, class of 1893, who was born in the same year as the Wayne State University School of Medicine, will receive the Centennial Alumni Award during the School of Medicine's Annual Clinic Day and Alumni Reunion, Wednesday, May 15, at the Sheraton-Cadillac Hotel in Detroit.

Other highlights during the annual Reunion Dinner-Dance in the evening will be the presentation of Golden Anniversary diplomas to the class of 1918 and the presentation of honors and scholarship awards.

Four medical alumni will receive Distinguished Service Citations: Peter J. Talso, M.D., professor and chairman, department of medicine, Loyola-Stritch School of Medicine; Fred Harbert, M.D., chairman, department of otolaryngology, Jefferson Medical College; Edwin T. Nishimuru, M.D., chairman, department of pathology, University of Hawaii School of Medicine; and Jules H. Masserman, M.D., chairman, department of psychiatry, Northwestern University School of Medicine.

General theme of the five scientific sessions to be held throughout the day from 8:30 AM to 4:30 PM will be "Human Sexuality and Modern Marriage."

Experts from around the nation will be involved during the five sessions. Titles of their talks are as follows: "Human Sexuality — A General View;" "Acquired Sex Attitudes and Information — Role of Home and Parents;" "Changing Sexual Expectations in Women — the Special Role of the Physician's Wife;" "Marriage and Sexual Problems in Modern Society: An Overview of Pre-Marital and Marital Counselling;" and "Psychodynamics of Teaching Medical Students Sex Education." In the late afternoon speakers will get together for a panel question and answer period.

Reservations for the clinical program and dinner dance may be made by writing Alumni House, Wayne State University, Detroit 48202.

Professional Concept, Topic For MAP Meet

The Ninth Annual Congress of the Professions, scheduled for May 10-12 at Boyne Highlands in Harbor Springs, will focus on "Practical Aspects of the Professional Concept" as its over-all theme.

Implications of this theme will be discussed at the 2:30 PM general assembly meeting, Saturday, May 11. The general assembly will be chaired by Chauncey A. Norton, C.P.A., from Detroit. The panels will discuss "Professional Liability and Professional Privileges" and "Collective Bargaining, Sanctions and Fee Schedules."

Some of the other highlights of the meeting will be the reception for Gilbert B. Saltonstall, M.D., president of MAP, from Charlevoix, on Friday evening, May 10, at 6:00 PM; the MAP awards luncheon, May 11; and the dinner dance, May 11.

COHEN TO SPEAK TO MPHA MAY 9

New Secretary of the Department of Health, Education, and Welfare Wilbur J. Cohen will be the banquet speaker, Thursday evening, May 9, during the Annual Conference of the Michigan Public Health Association at the Jack Tar Hotel in Lansing. Mr. Cohen will discuss the "Health and Social Problems Ahead."

Another highlight will be the presentation of an award to John K. Altland, M.D., director of the Office of Medical Services, Michigan Department of Social Services, for his many years of outstanding service in the field of public health.

Programs for the Conference are available from: Anna Lampela, Executive Secretary, MPHA, 2429 Delta River Drive, Lansing 48906.

MSMS Supports Hospital Forum At Boyne in May

The program for the second Medical Staff-Trustee-Administrator Forum, May 8-11 at Boyne Mountain Lodge, will focus on problems common to the physician, trustee, and administrator.

Speakers will include George Slagle, M.D., of Battle Creek, on the subject "A Practitioner Looks at the Hospital," D. Bonta Hiscoe, M.D., of Lansing, on "Organizational Relationships," Kenneth B. Babcock, M.D., of Fort Lauderdale, Florida, former director of the Joint Commission on Accreditation of Hospitals, on "Standards – Their Relations to Quality," and Kenneth J. Williams, M.D., of Detroit, and Leo Walker, M.D., of Lansing, who will participate in a discussion of "What Should Limit the Functions of a Modern Hospital? – Legal and Ethical Considerations."

Julien Priver, M.D., Detroit, is chairman of the forum.

The forum is sponsored by the Michigan Hospital Association, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons, and Michigan Osteopathic Hospital Association. The committee hopes to exceed last year's attendance, which numbered 225 persons.

WSU PROGRAM APRIL 26-27 ON COLON CANCER

The Wayne State University School of Medicine will sponsor a symposium on "Colon Cancer," April 26-27, at the Wayne County Medical Society Headquarters in Detroit. V. K. Vaitkevicius, M.D., director of oncology at the WSU Medical School, is chairman of the meeting.

Full details on speakers and topics can be obtained from the WSU School of Medicine, 1400 Chrysler Freeway, Detroit 48207.

MICHIGAN
LAND OF HOSPITALITY

"Michigan Week is much more than a celebration," said Win Schuler, of Marshall, chairman of the Michigan Week Committee which met recently in East Lansing. "It is a time for renewal, rekindling and rebuilding pride in our great state and determination on the part of all of us to work together for its advancement."

Mr. Schuler met with 100 key committee chairmen to start the final six weeks push toward the big celebration, May 19-25, intended to enlist all eight million citizens in Michigan promotion and betterment programs for the coming year. The theme is "Michigan – Land of Hospitality."

Cancer Foundation Begins '68 Crusade

The Michigan Cancer Foundation is observing April in Wayne, Oakland, Macomb and Monroe, as Cancer Control Month. Free educational movies are being shown in neighborhood theaters. The films are "A Habit for Life" about uterine cancer and "A Breath of Fresh Air" about breast cancer. A physician will address the audience at each showing and be available for a question and answer period.

The Michigan Cancer Foundation concentrates its efforts during April on public education in the importance of early detection for the cure of cancer.

Michael J. Ference, Jr., vice president-scientific research staff of the Ford Motor Company, is the chairman for the annual April Crusade. Michael J. Brennan, M.D., Foundation president, explains the slogan of the Foundation campaign this year is "Sometimes a person wonders. . . ."

Medical Societies to Help Sponsor Four Health-O-Ramas

More than 30 educational and scientific exhibits and 12 free medical tests will be available to Detroit area residents at Health-O-Ramas to be held April 25-27, at Northland, May 16-18, at Westland, May 23-25, at Eastland, and June 8-9, at Wayne State University's Old Main Building. The Health Careers Mobile will visit all four.

The Wayne State Health-O-Rama will be held from 10 AM to 6 PM. The other three will go from 11 AM to 9 PM daily.

Sponsored by Women for the United Foundation, the United Health Organization, the Michigan State Medical Society, and several other organizations, the Health-O-Ramas will offer free screening tests for anemia, blood pressure, cancer, cholesterol, diabetes, glaucoma, hearing, height and weight, oral cavity and vision, and a chest X-ray which will be checked for lung cancer, emphysema, enlarged heart, and tuberculosis. Approval for the screening activities has been given by the Wayne and Oakland Medical Societies.

Test reports will be sent to the private physician of the person who is screened.

DETROIT TO HOST BIG SCIENCE FAIR

Joining dignitaries from the American Medical Association, the American Pharmaceutical Association, and other organizations at the Health Awards Banquet on May 16 in Detroit, during the International Science Fair, will be several top MSMS officers. The '68 major International Science Fair will be held May 15-18 at Cobo Hall. Student participants will be the nation's most talented students in science who have won the trip to Detroit by surviving competition in local and regional science fairs.

Alma College to Sponsor Workshop for Doctors, Clergy

Speaking at the recent Medicine and Religion workshop held at MSMS headquarters in Lansing recently, Rev. Paul Barru, of Alma College, outlined plans for a physician-clergy workshop, May 2, at Dow Auditorium in Alma.

The program, entitled "The Pastor in the Sick Room – a Help or a Hindrance," will begin at 9:30 AM and conclude at 3:45 PM.

Keynote speaker will be Rev. Robert B. Reeves, Jr., chaplain of Columbia-Presbyterian Medical Center of New York City. Also on the program are Albert Heustis, M.D., of Lansing; Bruce Danto, M.D., of Detroit; Miss Irene M. Willard, Saginaw; and Mr. Ernest Laetz, assistant director of the University of Michigan Hospital.

Moderating the program will be Rev. Paul McCleave, director of the department of Medicine and Religion at the American Medical Association.

Taking part in the recent day-long workshop on Medicine and Religion at MSMS headquarters in East Lansing, are: (left to right) Rev. Paul S. Barru, Alma; Albert E. Heustis, M.D., East Lansing; Robert Coons, from the staff of the AMA Department of Medicine and Religion; LeRoy Augenstein, Ph.D., luncheon speaker who is chairman of the biophysics department at Michigan State University; Rev. Paul McCleave, LL.D., director of the AMA Department of Medicine and Religion; and Winslow G. Fox, M.D., Ann Arbor, state chairman of the MSMS Committee on Medicine and Religion.

TRAUMA SYMPOSIUM MAY 1, MUSKEGON

HARTWELL

"Skin Coverage of Wounds," "Amputations in Children – Acquired and Congenital," "Abdominal Trauma," "The Problems of Hepatic Injury," "Multiple Injured Patient," and "Hypnosis" – these are the topics which will be covered at the Eighth Annual Symposium on Trauma, May 1, in Muskegon. The symposium will be held at the Holiday Inn.

Speakers will include Shattuck Wellman Hartwell, Jr., M.D., of the Cleveland Clinic. Sponsored by the Michigan Committee on Trauma and the Muskegon County Medical Foundation, complete details on the symposium can be obtained from Emil J. Lauretti, M.D., Chairman, at 205 Medical Arts Center, Muskegon.

Life Editor Speaks May 2

George P. Hunt, managing editor of *Life Magazine,* will give the 1968 Charles Maurice Yates Memorial Lecture at 4 p.m., May 2 in the Erickson Kiva at Michigan State University. His topic will be the press and the publishing of scientific medical research.

The general public is invited to the lecture which is co-sponsored by the Michigan TB & Respiratory Disease Association, MSMS, the MSU School of Journalism, College of Human Medicine, College of Veterinary Medicine and Institute of Biology and Medicine.

Mr. Hunt is the brother of Andrew D. Hunt, Jr., M.D., Dean of the MSU College of Human Medicine.

State Arthritis Session May 10-12 To Assess Care

Between 75 and 100 professionals in the various health fields will meet for the first "Michigan Conference on Arthritis" at Dearborn Inn, May 10-12, according to James J. Lightbody, M.D., of Detroit, Medical Director of the Arthritis Foundation in Michigan and President-Elect of MSMS.

"This will not be an educational conference devoted to diagnosis and treatment," Doctor Lightbody said. "Its purpose is to assess the presently available facilities for treatment of arthritis in Michigan and to determine if there are gaps in physician, hospital, and physical therapist services. If there are, we want to see what can be done to improve them."

The keynoter will be William Robinson, M.D., professor of medicine and head of the department of medicine at the University of Michigan Medical Center. Doctor Robinson is a former president of the American Rheumatism Association.

The Conference will be sponsored by MSMS, the Arthritis Foundation of Michigan, the three medical schools, and the public health department.

DETROIT YOUTHS LOOK AT CAREERS

"The Expanding Field of Health Careers: Today and Tomorrow" was discussed by Louis F. Hayes, M.D., vice-president for medical affairs, Michigan Medical Service, at a conference for high school students interested in health careers which was held at Mercy College in Detroit recently. The Health Careers Mobile was at the campus throughout the conference.

Muscle Symposium May 22 at WCMS

The Annual Muscle Symposium, May 22 at the headquarters of the Wayne County Medical Society in Detroit, will feature four major topics. Authorities from around the nation will discuss "The Neurosurgical Concepts and the Management of Contractures in Musculo-Skeletal Disability;" "Recent Advances and Evaluation of Treatment of Muscle Disease;" "Rehabilitation Aspects of Muscle and Nerve Disease;" "The Diagnosis in Terms of Muscle Tone, Weakness, and Atrophy."

Sponsored by the Muscular Dystrophy Association, Wayne State University Department of Neurology, and the Detroit-Macomb Hospital Association, the symposium will begin at 9:00 AM and end at 5:00 PM. There is no registration fee.

GET MDPAC TIPS AT WORKSHOP

Members of the MDPAC board and guests represented Michigan at the AMPAC workshop in Washington recently. Left to right are Ralph T. Wills, MSMS staff; Edgar J. Geist, Jr., M.D., Oakland county; Vernon V. Bass, M.D., Saginaw, chairman of the MDPAC Board of Directors; Congressman Melvin Laird, of Wisconsin; James J. Lightbody, M.D., Wayne county; Robert J. Franck, Jr., M.D., Gogebic county; Donato Sarapo, M.D., Lenawee county; James Rosevear, AMPAC representative, and Jack Brown, AMA representative.

MSMS SPRING, 1968 PG CALENDAR

LOWER PENINSULA

Alpena, April 18
Battle Creek, May 7
Cadillac, May 23
Grayling, April 25
Lansing, May 21
Livingston County, May 7
Midland, May 9
Muskegon, May 15
Niles, May 21
Ottawa, May 3
Petoskey, April 11

UPPER PENINSULA

Escanaba, May 14
Houghton, May 13
Iron Mountain, May 15
Ironwood, May 14
Manistique, May 14
Marquette, May 16
Menominee, May 15
Sault Ste. Marie, May 13

Fill in and mail to MSMS, 120 W. Saginaw, East Lansing 48823

Please Register Me
For Conference May 8
For Physicians and Coaches

I will attend the MSMS Conference in Detroit on the Medical Aspects of High School Sports at the Rackham Building, May 8. I agree to pay the $3.50 for the luncheon; and understand there is no registration fee.

Name

Address

City

Team Doctors, Coaches To Confer in Detroit May 8; Register Now

All MSMS members, and team physicians especially, are invited to attend the 1968 MSMS Conference on the Medical Aspects of High School Sports in Detroit, May 8. Several hundred physicians, high school coaches, trainers, and interested school administrators attended the 1967 event.

The third annual conference will be held this year in Detroit, in recognition of the WSU Medical School Centennial. The program will be at the Rackham Building, on Woodward at Farnsworth near the art gallery and library. There is abundant underground parking. Co-sponsoring the program will be the Center for Adult Education, a cooperative venture of the University of Michigan, Wayne State University and Eastern Michigan University.

Headline speakers will be the team physicians for the Notre Dame Irish and the Ohio State Buckeyes.

James S. Feurig, M.D., MSU team physician and chairman of the MSMS Committee on Medical Aspects of Organized Athletics, will preside.

WEDNESDAY, MAY 8, 1968
RACKHAM BUILDING, DETROIT

9:30 a.m. to 10:00 a.m.

Registration

10:00 a.m. to 11:00 a.m.

"Ankle & Knee Injuries"; Leslie M. Bodnar, M.D., Attending Orthopaedic Surgeon, St. Joseph's and Memorial Hospitals, South Bend, Indiana and Orthopaedic Consultant, University of Notre Dame.

11:00 a.m. to 12:00 noon

"Drugs In Athletics"; Robert J. Murphy, M.D., Internist, Columbus, Ohio, Team Physician Ohio State University.

12:00 noon to 1:15 p.m.

Luncheon

1:15 p.m. to 2:15 p.m.

"Mouth Injuries"; Julius Franks, Jr., D.D.S., Dental Surgeon, Grand Rapids, Michigan; Varsity Football Player, University of Michigan 1940-42, All American Guard.

2:15 p.m. to 3:15 p.m.

"Medical Aspects of Athletic Conditioning"; Robert J. Murphy, M.D.

3:15 p.m. to 4:15 p.m.

"Athletic Injuries with Normal Findings on Routine X-ray Examination"; Leslie M. Bodnar, M.D.

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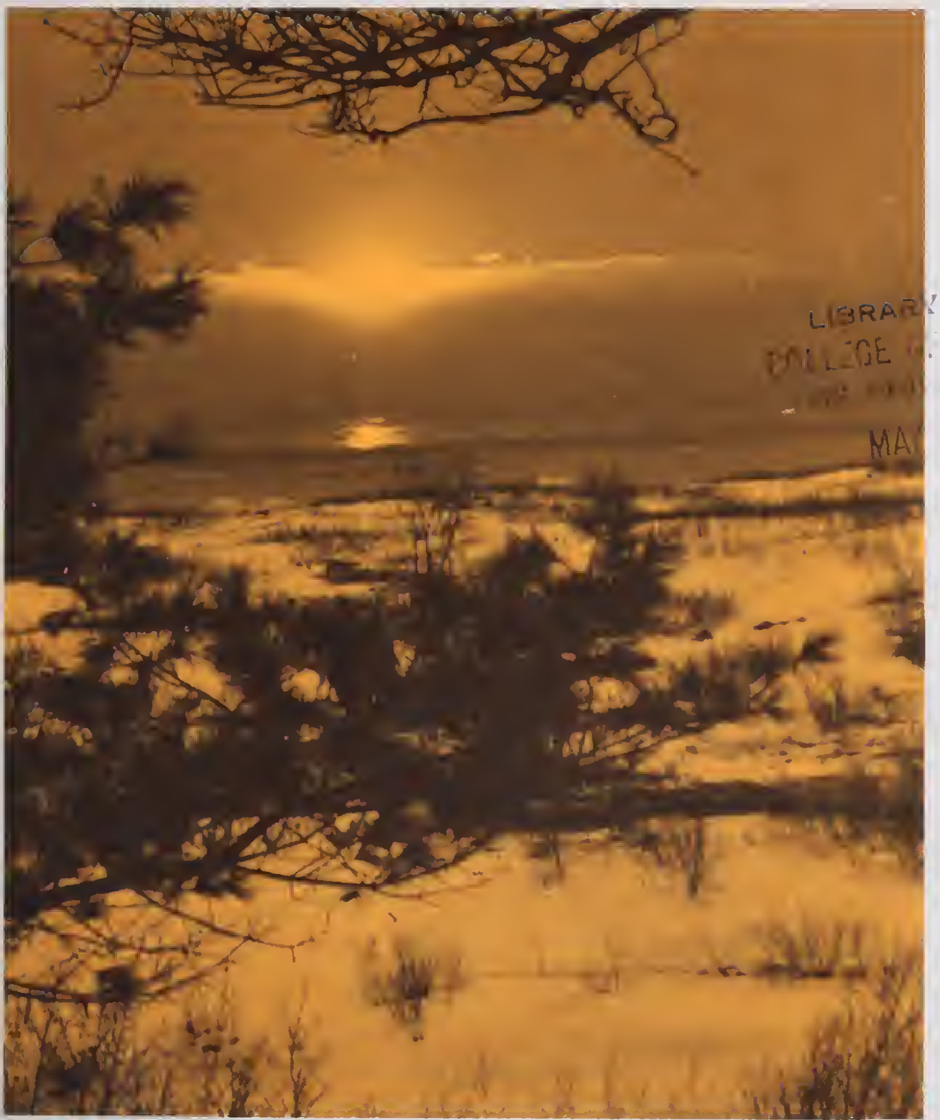

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Beautiful Scenes,
Michigan People
Extend Hospitality
During Michigan Week
And Throughout Year
— See Page 571

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 9
MAY 1968

AMONG THE IMPORTANT ARTICLES:

President's Page about Michigan Week
Aging, 1968
WSU Curriculum Study Report
State Health Services Study Report
Rural Emergency Medical Service
Special Smoking-Health Feature

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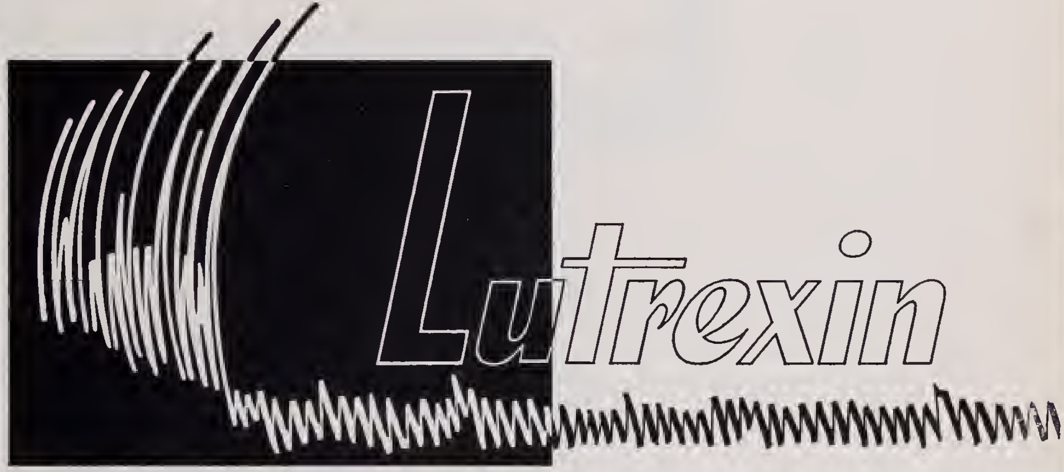

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MICHIGAN MEDICINE

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SMOKING-HEALTH FEATURE

A four-page layout about the Michigan Council on Smoking and Health begins on Page 679. Physicians are urged to use the special order blank to obtain educational materials.

ABOUT THE COVER

The cover photograph this month is a typical scenic view of Michigan as attention is focused on Michigan Week, May 19-25. Please read the President's Message by B. M. Harris, M.D., this month for more information about the 1968 Week. The photograph, looking out over sand dunes toward Lake Michigan, was taken by Managing Editor Herb Auer north of Muskegon.

The sketch on page 599 was done by Craig Dennis, a senior at Lansing Eastern High School who hopes to become a medical illustrator.

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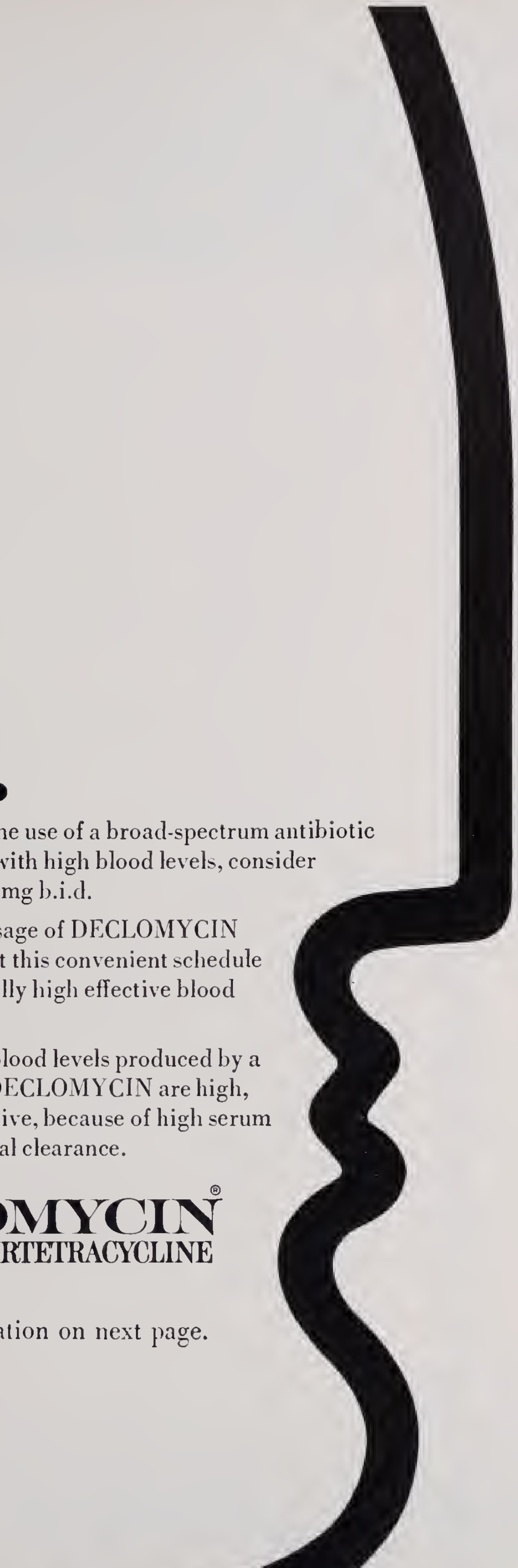

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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. **Side Effects**—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

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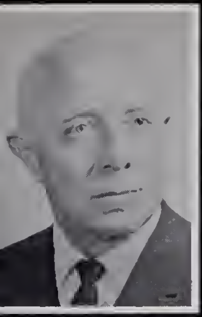

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

"Michigan Week 1968" is celebrated during May 19-25. This is a project of the Greater Michigan Foundation in which all sorts of people participate. Good results seem to accrue to Michigan.

The board of governors of the Greater Michigan Foundation consists of 90 men who represent business, education and labor. Their President is Dale I. Sellers of Detroit. The purpose of the Foundation is to conduct volunteer programs for Michigan's progress, but most of its activities are built around the annual Michigan Week in the spring. Don Weeks is Executive Director and Win Schuler of Marshall is General Chairman of the 1968 Michigan Week. The MSMS Executive Director, Hugh W. Brenneman, is the perennial Chairman of the Professions Committee of the Michigan Week.

THIS WEEK COMES at a most fortunate time and the subject, "Michigan—Land of Hospitality" is especially apropos. There are tremendous social, economic, political, and human forces at work in the state. The extent to which we are successful in dealing imaginatively and progressively with these forces will determine the future of our state.

While the truth that "only a lawful society can build a better society"* is self-evident to the thoughtful, it must be equally true that harmony with the spirit of the law is as essential as adherence to the letter of the law in a progressive society.

How is that harmony engendered? Michigan Week has one answer. It uses the stimulant, the pep talk, the showmanship, the sales approach. And let it not be said that this approach is unimportant because it sells, and sales are necessary to remind us of our objectives and to present those objectives persuasively to others. But no matter how good the hoop-la, it must be followed up on the other 51 weeks of the year with solid evidence—actions proving that the advertising is legitimate, not phony. The masters of Michigan Week are the first to agree with this.

BUT IT IS ONE thing to call for friendly acts and quite another thing to program and carry them out.

The evincing of friendliness on an organizational basis is not quite so simple. People ignore weak organizations and fear strong ones. How often do they feel friendly toward the inanimate things called associations? The answer lies in the ability of the association to demonstrate its concern for the public interest and for people as individuals. What has your county medical society done to demonstrate its concern for your community's welfare *this week?* What project has your medical group carried out on an organized basis to demonstrate its desire for friendly intercourse with other segments of your community?

THE ABOVE THOUGHTS are not offered as preachments but rather as suggestions to which I take the liberty of adding a final one. Your county medical society woman's auxiliaries must be constantly reassured that you need them. They can be great assets. Just as the doctor's wife is his hospitality councilor and aide, so the woman's auxiliary can be the hospitality councilor and aide to the county medical society and they will be if they are asked.

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*Theme of Law Day U.S.A. 1968

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VIEWPOINTS

Thoughts about the Cost Of Medical Education

BY DON MARSHALL, M.D.,
COUNCILOR, KALAMAZOO

Modern society needs physicians. Physicians have to be educated for their work. Who should pay for this education? The same questions could be asked for teachers, engineers, etc.

Under the free enterprise system of the past, a man desiring to acquire medical training received it by meeting academic requirements and paying tuition. An embryo engineer did the same, as did other professionals. Personal preference determined which vocation a youth entered. Supply and demand, and his own ability, largely determined his later success.

When the supply fails to meet adequately the demands of society what should be done? If there aren't enough physicians or nurses or physicists or teachers is anyone responsible for increasing the supply? Is each profession responsible, or are universities, or is Congress, as the executive of society?

AND WHO SHALL pay the cost?

In most advanced countries the world over the wealthy have been able to obtain whatever kind and degree of education desired, provided they demonstrated adequate intellectual capacity and ambition. In most free-enterprise countries it has been more difficult, and sometimes impossible, for the poor to do the same, because of their poverty.

In recent decades an increasing flow of private and federal loans, grants and scholarships has partly obliterated this differential. In fact, students in many science fields have had much of their education subsidized. Only more recently has it become a fact that no established medical student need leave school for financial reasons.

IF THE ABLE BUT financially-poor student is subsidized in order that society may benefit from his ability or genius, and if other students are subsidized because society needs them as trained professionals, has the aided student obligated himself to his benefactors, or is he still free and independent? If a medical school accepts large sums from state and federal governments, does it thereby abandon its academic freedom and become a prostitute of the legislature?

The National Health Manpower Commission has urged federal loans to medical students "to cover the full costs of tuition and living expenses during formal professional education." The AMA has replied that this would not necessarily increase the number of applicants or change the number coming from poor families. The AMA does agree with the need for more direct support of the educational functions of medical schools.

U.S. MEDICAL SCHOOLS in 1966-67 had a total enrollment of 33,423. Loans were made to 54.6% of these students, and scholarships granted to 22.7%. The loans totalled $18,773,992 and the scholarship funds $6,379,320. Loans and scholarships each increased in dollar value over the previous year. While in this past year 55% of all medical students borrowed money to continue their education, only 11% did it nine years earlier. Last year 23% of students were awarded scholarships, averaging $800 each. Nine years earlier the figures were 10% and $512. Probably some students fall in both categories. The amount of funds borrowed by medical students from government sources is rising while that from private funds is falling.

Medical schools are now approaching an annual total expenditure of a billion dollars. This includes both regular and sponsored programs. 54% of the expenditures now are from federal funds, nearly all of it for research and sponsored programs.

MEDICAL STUDENTS and medical schools face today a problem common to many aspects of our life: How can we afford all that we need plus all that we want without incurring complete socialization and federal control? How can we afford both butter and guns? How can we afford both to double our educational facilities and wipe out our ghettos?

A practical answer is that we can not afford not to do so. It will be far cheaper to rebuild our slums than to handle guerilla warfare. It will be cheaper to educate more members of the health team than endure the drop in health and morale that would otherwise ensue. And in the process the private sector of our people must constantly realize that, generally, government steps only into vacuums, and does not enter those aspects of our

Continued on 574

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life where private enterprise is doing a job that satisfies the public.

SO YOU AND I, the medical profession, all professions, the public, private business and foundations, together must do all we can to support medical students and medical schools, to support education, to support slum clearance and the removal of the sores in our society.

This will take priorities. The money that today goes into tobacco, alcohol and cosmetics would be a great help if spent in better directions. Farm and oil subsidies and many other government handouts should be cut back to a more logical size, or abolished. We who live in luxury should give up a fair share of it to meet the needs of society, and not leave the job to Congress.

Medical education ideally should be paid for by the students so far as he is able, by private loans and philanthropy from there on, and only when there is no alternative by government subsidy, both state and federal. Since the average citizen is loath to give away his earnings, government by taxation forces him to contribute his share. Trying then to spend it wisely, Congress puts strings on the pocketbook. If private giving were widespread and generous enough, the administrative overhead cost and the restrictions imposed from Washington could be avoided. ☐

Smoking-Health Council Offers Materials, Page 679

BY BROOKER L. MASTERS, M.D., CHAIRMAN, PUBLICATION COMMITTEE

Over the past several years many physicians, recognizing the health hazards of cigarette smoking, have taken it upon themselves to discourage the habit by stopping smoking, and in so doing, setting an example for their patients and the public-at-large.

Michigan physicians are concerned about cigarette smoking and many have taken it upon themselves to participate in programs and committees to educate youth and adults about smoking and its relationship to health and disease. One way in which physicians are active, and heard, is through Michigan State Medical Society's mem-

Continued on 576

ANNUAL MEETING OF THE MUSCLE SYMPOSIUM

Auditorium of Wayne County Medical Society

Wednesday, May 22, 1968 — 9 a.m. to 5 p.m.

Sponsored by: **Muscular Dystrophy Associations of America, Inc., Metropolitan Chapter, Department of Neurology, Wayne State University School of Medicine. Detroit-Macomb Hospitals Association.**

Speakers: Dr. Ade Milhorat, Medical Director of the Institute of Muscle Disease, New York City.
"Recent Advances and Diagnosis of Treatment of Muscle Disease"
Dr. Paul Vignos, Case Western Reserve University, Cleveland
"Diagnosis of Muscle Tone, Weakness and Atrophy"
Dr. George Koepke, University of Michigan, Ann Arbor, Michigan
"Rehabilitation aspects of Muscle and Nerve Disease"
Dr. Harry Ingberg, Wayne State University—Detroit, Michigan
"Electro-Diagnostic Procedures"
Dr. Erwin Siegel, University of Illinois, Chicago
"Neurosurgical concepts and the Management of Contractures in Musculo-skeleto Disability"
Dr. John Stirling Meyer and staff will present **"Neurological Aspects"**

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M. K. Newman, M.D., Chairman of Muscle Symposium
16861 Wyoming Avenue, Detroit, Michigan 48221

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bership in the Michigan Council on Smoking and Health.

Michigan Medicine, in cooperation with the Publicity and Public Relations Committee of the Michigan Council on Smoking and Health, has prepared four special pages, 679-682, containing the most recent information on smoking; activities of the Council; and a listing of publications for physicians and patients which are available in quantity from the Council through the fine cooperation of its member agencies.

We hope each physician will review the information and request copies for his use, and for placement in his waiting room for patients to read and take with them. □

Books Received for Review

Sensorineural Hearing Processes and Disorders. Edited by A. Bruce Graham. 559 pp. Illustrated. $19.00. Little, Brown and Company, Boston, Massachusetts, 1967.

Diabetes Mellitus: Diagnosis and Treatment, Volume II. Edited by George J. Hamwi and T. S. Danowski. 250 pp. $2.50. American Diabetes Association, Inc., New York, 1967 □

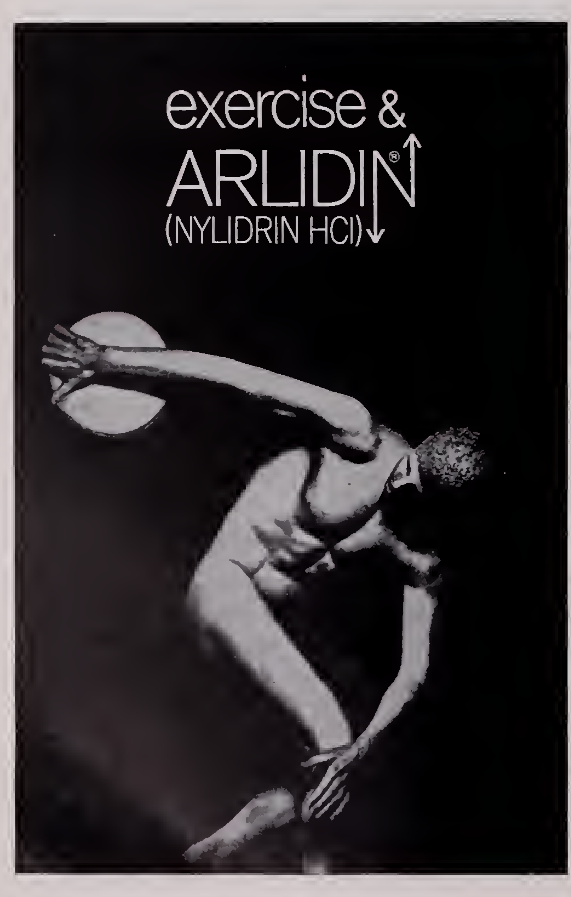
ARTICLES INVITED

A very definite advantage to authors who submit original material to *Michigan Medicine* is the early publication date that is possible in contrast to the time usually required in national or international publications. The Publications Committee welcomes controversial papers as long as they have the merit of being based on well-considered opinion or experience on the part of the authors. Review articles of rapidly developing fields of medicine are also invited.

— *George H. Lowrey, M.D.*
Scientific Editor

Recommended Reading:

The libraries have available the book by Harriet H. Naylor entitled "Volunteers Today — Finding, Training and Working With Them." The book brings new insights and experience from adult education, social work, sociology and psychology to the problems of getting, developing and holding new kinds of volunteers in the face of keen competition. □



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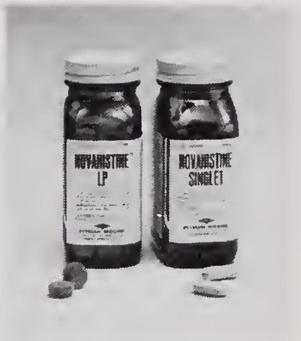

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Dear Doctor Harris:
I read with interest your "President's Message" in the February issue of *Michigan Medicine*. We are always pleased to learn about people in leadership positions who are giving attention to the importance of health education.
Our staff was particularly interested in your reference to the role of a physician as a consultant to schools and other community groups with respect to health education. As you indicated, physicians do carry on health education every day in the privacy of their consultation rooms, but they also have a responsibility in the community.
We certainly stress the specific points you made with respect to sex education, venereal diseases, general health protection, and drug abuse. We hope, however, that efforts to implement teaching about these significant topics will be part of an overall program of health education in schools and communities.
Sincerely,
Fred V. Hein, Ph.D., Director,
AMA Department of Health Education

I'm extremely pleased with the interest shown by members of the Woman's Auxiliary at the first annual Legislative Day at the MSMS Headquarters in East Lansing.

You are to be commended for having such an excellent staff as everyone at MSMS was most gracious and helpful.

We do appreciate everyone's efforts.

Frances Gamble, President
State Women's Auxiliary

We think the article "A Pediatrician's Cue to Psychiatric Problems of Children" by H. Mark Hildebrandt, M.D., Ann Arbor, in the most recent issue of Michigan State Medical Society AID bulletin, is just what teachers and many other lay people concerned with mental health need to help parents decide when a child needs help.

With your permission, we would like to duplicate the article and also use it in our local newspaper.

Mrs. Lewis M. Birckhead
Mental Health Services Study Group
Grand Haven

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Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

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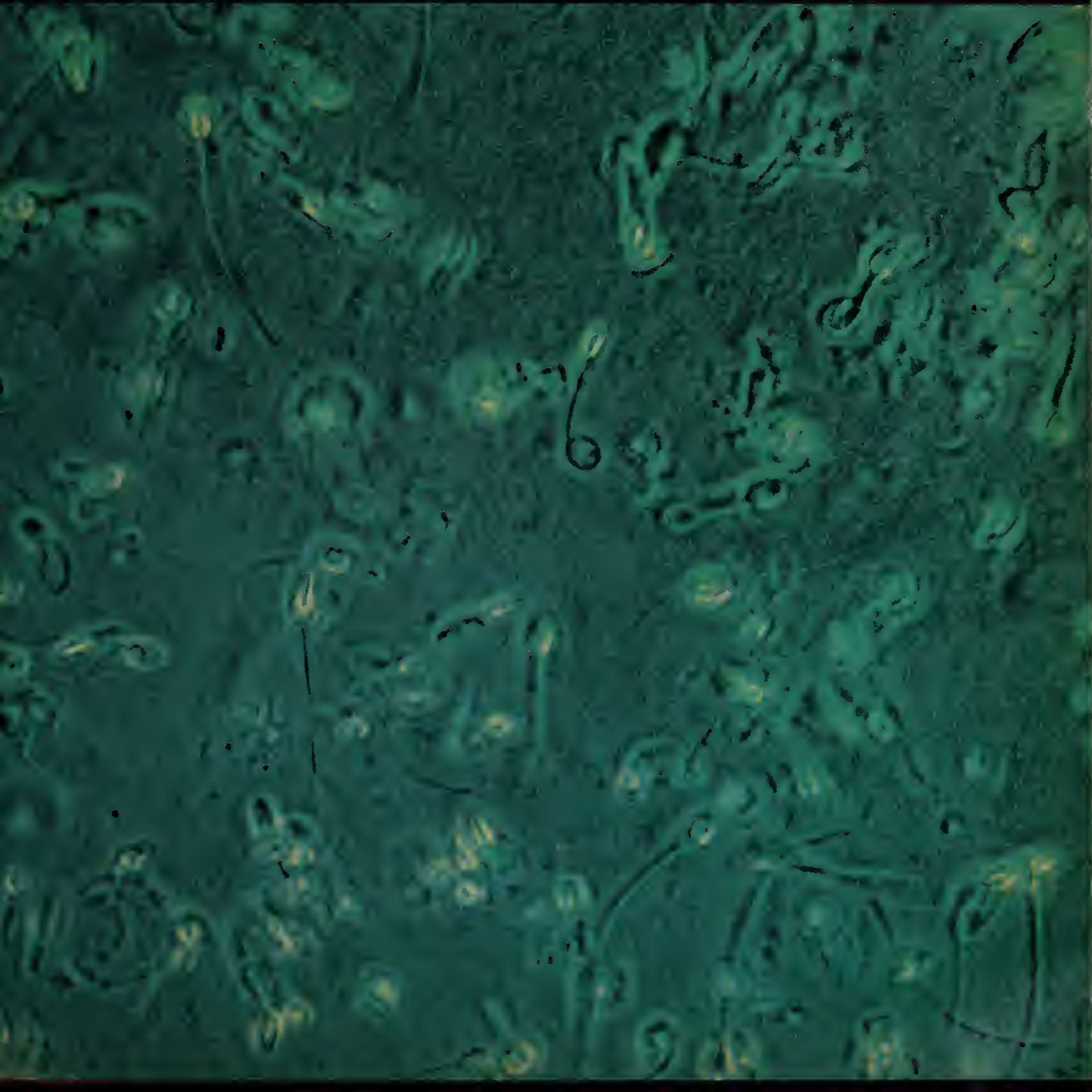
When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. Th age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (suc as abdominal cramps and bloating) breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlarge ment and secretion), change in wei (increase or decrease), changes in cervical erosion and cervical secreti suppression of lactation when give immediately postpartum, cholestati jaundice, migraine, rash (allergic), rise in blood pressure in susceptibl individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, chang in libido, changes in appetite, cystit like syndrome, headache, nervousn dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema noc sum, hemorrhagic eruption, itchin

The following occurrences have bee observed in users of oral contraceptives (a cause and effect relationshi has been neither established nor di proved): thrombophlebitis, pulmon embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine an decrease in T^3 values), metyrapon test, pregnanediol determination.

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SYNTEX

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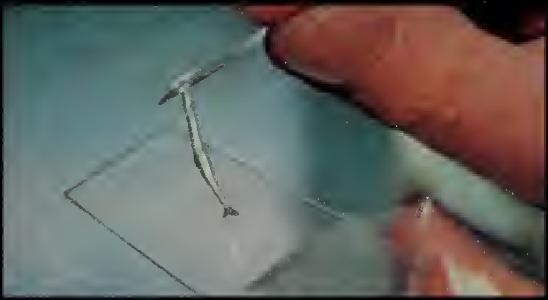
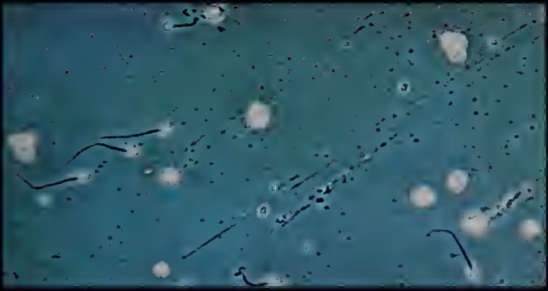
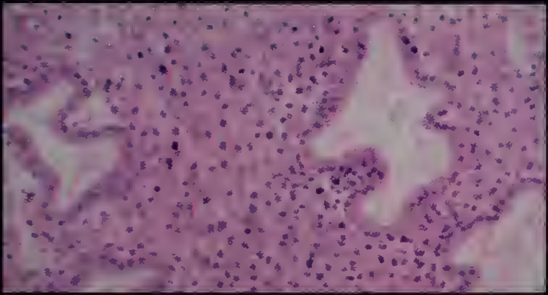
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

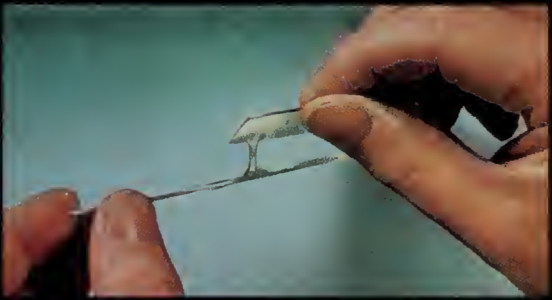


Spermatozoa appear healthy, active, freemoving.

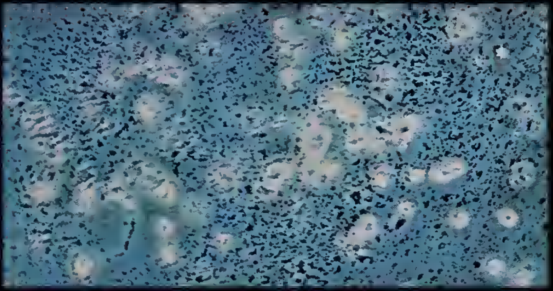


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

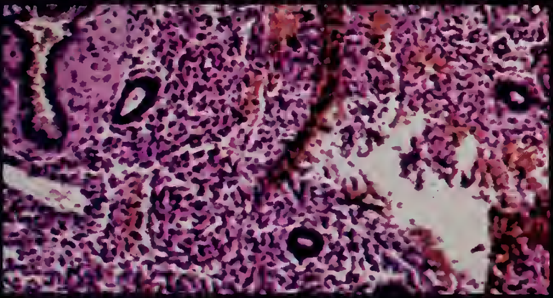
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



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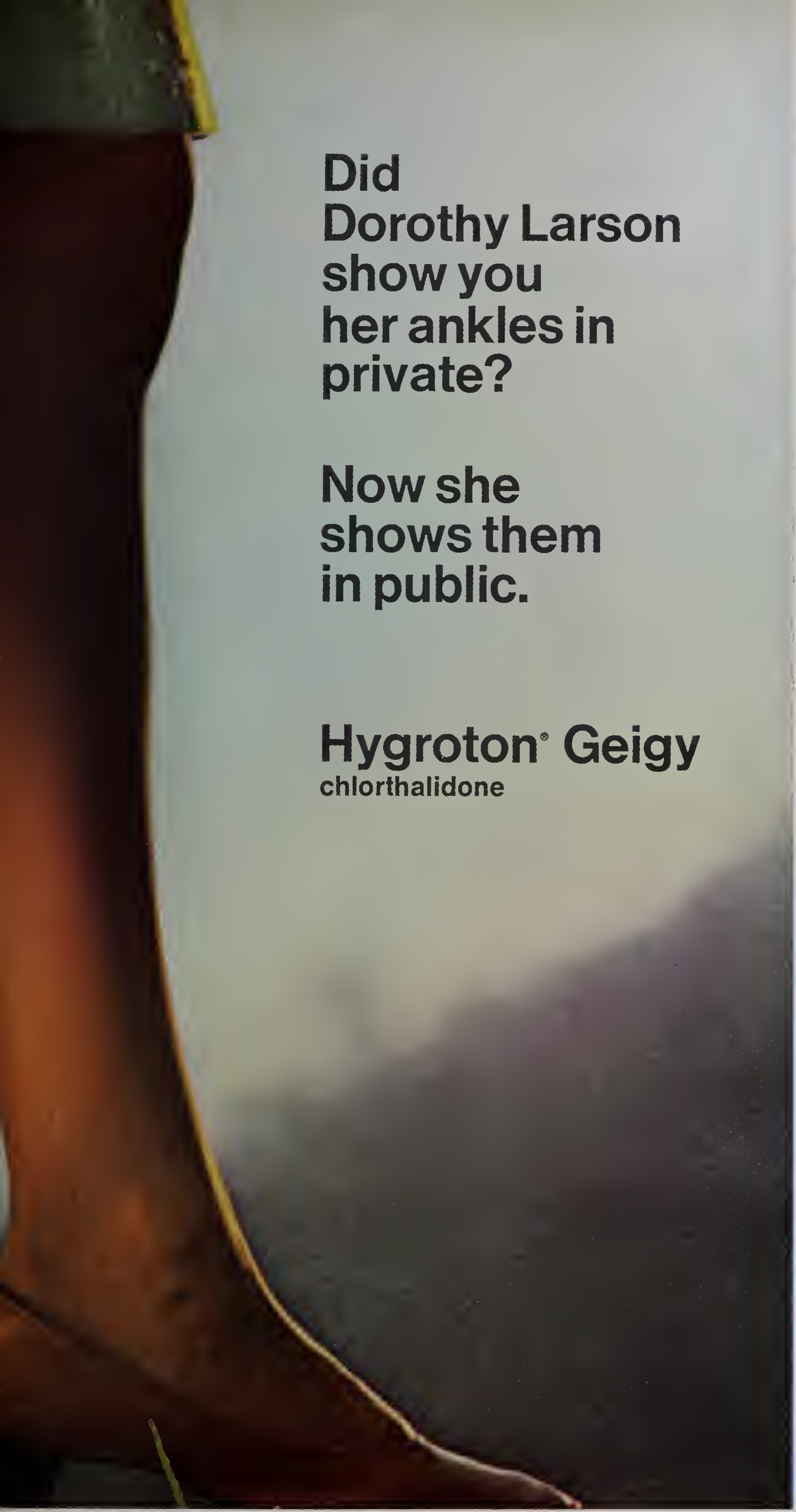

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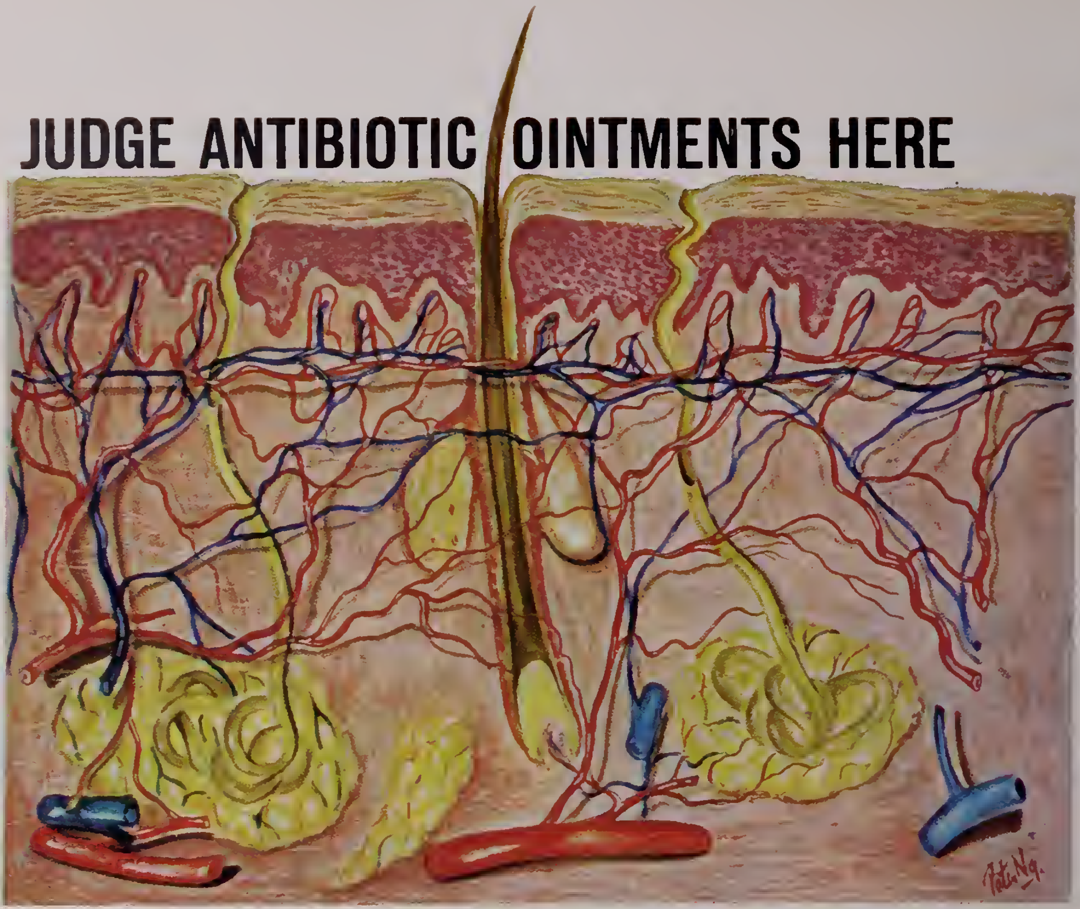

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M.D. Suicides . . . Why?

BY PHILIP M. MARGOLIS, M.D.
ANN ARBOR

At least 25,000 Americans kill themselves each year. I say "at least" because this number reflects only the "recorded" suicides. It is a highly understated statistic, especially when one takes into account automobile accidents, cover-ups, and the complexities of the unconscious. Suicide accounts for the tenth cause of death for all Americans, is in fourth place with teen-agers and is second with college students.

Physicians kill themselves at a rate considerably higher than the rest of the population. Statistics vary but it is clear that physician suicides are four to eight times oftener than the general population.

A SURVEY IN ENGLAND showed that the suicide rate for physicians is 2¼ times that of all males, and the majority of these deaths are of young men (under 45). More than 1 out of 50 male physicians kill themselves per year in England, accounting for 6% of all physicians' deaths (equal to the mortality from lung cancer).

To continue with the deadly statistical game, Freeman and DeSole report that suicide-deaths are highest in the field of psychiatry and ophthalmology, lowest in radiology. From 1895—1965 the physician accident-death/suicide-death ratio was 2 to 1; however, during these seventy years 208 psychiatrists died "accidentally" and 203 suicided (exclusive, of course of "concealed" deaths). And 54 of these 203 have killed themselves during the past five years; 81 did so before age 40. In fact, in the age group 25—39, 26% of physician deaths are suicides, as compared to a general (white) population rate of 9%.

How can these truly alarming statistics be explained?

Theories abound, some more credible than others.

MOST PHYSICIANS WHO commit suicide have been depressed and melancholy. One-half of those who suicide take drugs, which are readily available; with his adequate toxicologic knowledge the doctor is unlikely to misjudge the mortal dose. In fact, many are habitual drug users, even addicts. Some physicians who commit suicide have had "incurable" (medical) illnesses, and undoubtedly have been keenly awaie of their incurability.

Why do physicians seem significantly susceptible to a suicidal melancholia?

Freeman suggests that physicians' ideals may be too high, that productivity often falls far short. He feels that many physicians `neglect restorative and recreational activities which are intended to balance his intellectual activities underlying his creative drive. He is too task-oriented; he is too intense in his work. In a similar vein, a study at Albany Medical College suggests that the physician is afflicted with psychic tensions due to role strain, i.e., the contention that no roles other than intense and never-ending "doctoring" are available. There is a lack of opportunity for regression, for diversion and sublimation.

FINALLY, THE philosopher asks: Does acquaintance with death free the physician from the popular supernatural dread of it? After all, as Wilde commented in The Ballad of the Reading Gaol (1898), "the Doctor said that Death was but a scientific fact."

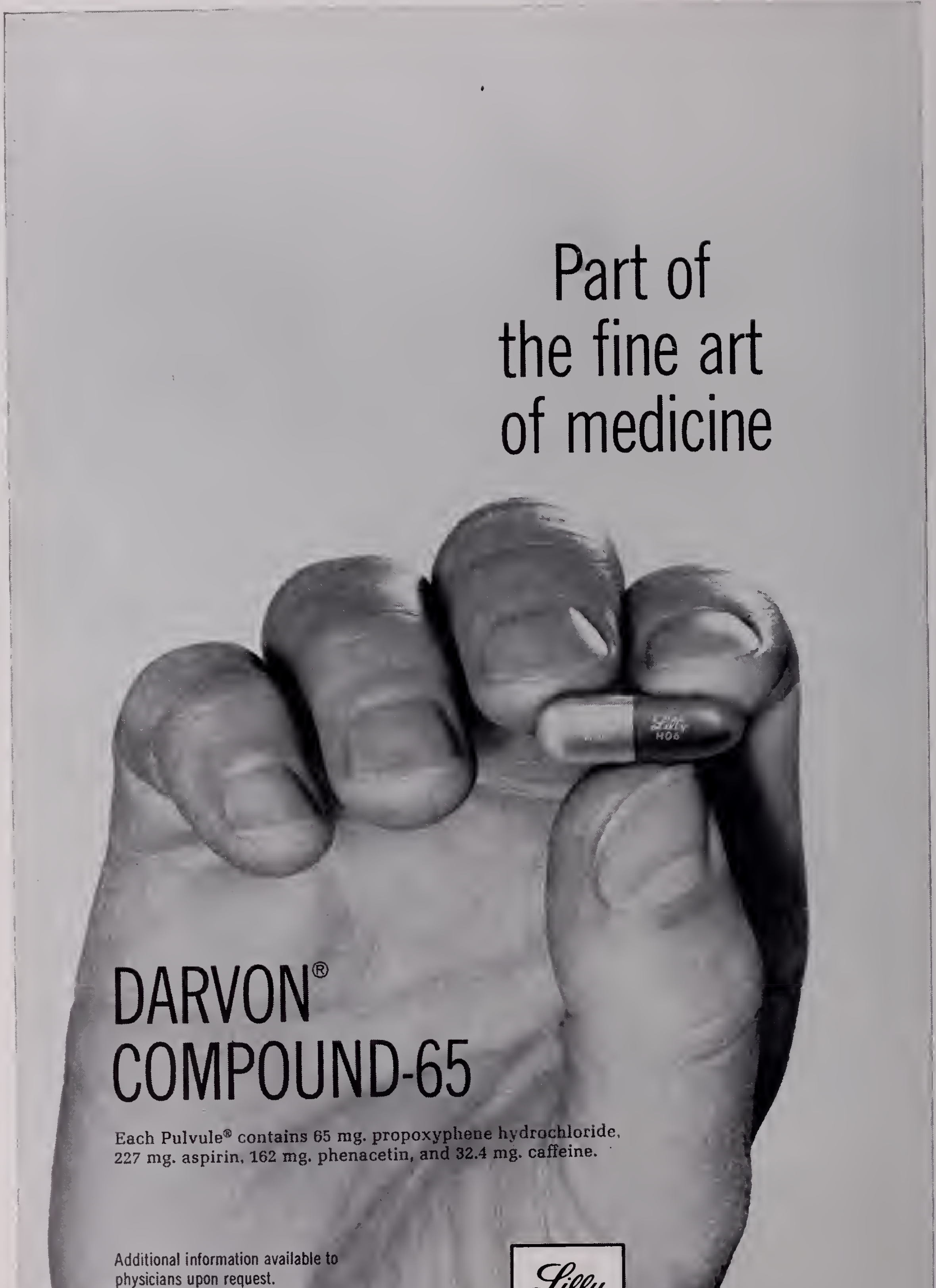
What to do?

Suicidal people usually give clues to their intentions, especially when they are depressed. Physicians are no exception though they may hide their symptoms better than others; the symptoms (at present) are little noticed and scarcely heeded. Physicians should be treated like any other patient, but they never are. Especially when the problems of the M.D. are emotional in nature, the "treater" must seek to understand these problems, at the same time studiously avoiding identification with his patient.

PERHAPS THE ANSWER really lies in prevention. Medical Schools need to pay more attention to the psychic structure of their applicants. For example, Litin suggests that the applicant be able to "shoulder the dependency needs of others." There is also some evidence that a well-rounded academic background (e.g., a solid interest in the humanities) is as or more important than a proficiency restricted to the sciences.

Physician, heal thyself?

Perhaps, but the first step is for him to become a "good" patient, to recognize his need for help and to seek it. If we can know and understand, then we can probably fulfill Maurois' powerful entreaty: to live as if we were eternal.



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Aging, 1968

BY FREDERICK C. SWARTZ, M.D.
LANSING

"Aging" in one concept or another has been a subject of extreme interest to man since the beginning of recorded history. Everyone has talked or written about it. The philosopher, the physician, the priest, the teacher, the poet and musician, the scientist and the researcher have all used the term. The distillate of these writings constitutes a description of the passing scene more than anything else, and, varies appropriately with the climate of the age, or the empire in which the writing occurred. This is true of all the contributions, no matter which discipline is represented. No one, so far as I know, has ever spelled out what they meant by "aging" or the "aging process."

Let me ask: what does "aging" mean to you?

How precise are your concepts of the changes "so-called" wrought by time?

Have you ever stopped to think of the differences that exist between those people whom you called old when you were a youngster, and those whom you call old now?

Has it not occurred to you that the concept of "aging" that existed 100 years ago must have been quite different from the concept of "aging" as it exists today?

WHEN THE GEOLOGIST talks about the aging rock on the hill, he is not referring simply to the passage of time. He uses this term to include those effects wrought by changing temperature, by the wind, by the rain, and by the heat of the sun. This usage, therefore, includes with the effects of the passage of time — if there be any such effects — also those changes wrought by the impact of other environmental forces. This concept of the process of aging admits that many of the results observed are produced by forces other than the passage of time. This is so very important, as we shall emphasize from time to time. It is this concept that gives us hope. It is this concept that gives us an area that we can attack in order to change the so-called process of "aging." All we have to do is modify those environmental factors which have contributed certain effects.

Many people from ancient times to the very present speak about the signs and symptoms, such as the tottering gait, the shaking hand, the white hair, the bald pate, the shrunken shank, the piping voice, the store teeth, the thickening glasses, the forgetful mind, the narrowed mental horizons, and the lack of motivation, the creaking joints, the stiffness and aching, as if these all were a part of a great syndrome which would lead to the diagnosis of the "aging process."

The big question of the moment then is: Are all these characteristics and many others alluded to by various writers the result of the passage of time? If this is true, then at any stated age we should all represent approximately the same proportion of the characteristics listed above and as time goes on we could expect to acquire all the other of the characteristics listed.

IF ALL OF THESE stigmata of "aging" are considered to result because of the passage of time, then there is no possible way for us to modify the final picture of old age. There are some who support this idea, both among the professional and non-professional. I am happy to report, however, that in the past few years more people in the health field are commencing to realize that any and all of the signs and symptoms witnessed among the aging represent some functional derangement related to the presence of a chronic condition or the lack of proper physical and mental exercise and are subject to the correctible methods of modern medicine.

In the more exact sciences we find more exact definitions. Not that we expect to introduce into medical circles this amount of exactness, yet the concept seems to me to be a necessary one. Thus, Boyle's Law says: "With temperature constant the volume of a given sample of gas is inversely proportional to the absolute pressure." And Charles' Law says: "With pressure constant, the volume of a given sample of gas is directly proportionate to the absolute temperature." In these two situations we have regulated those forces which might produce changes which would confuse the results for which we are searching. Therefore, in this concept of "aging," if we could, in essence, block off the effects of environment and cancer cells and bacteria and viruses we ought to witness in an animal or tissue culture those effects which are wrought by time alone. In our search of the literature we have found no such specific example where all possible contributing forces have been eliminated except the passage of time.

Certain disquieting thoughts are disrupting some previous sacred relationship between certain phenomena that were supposed to bear a direct relation to the passage of time.

LET US EXAMINE A few of these for the moment, not really to prove anything very great, but just as an effort to shake the foundations of those who continually talk about "aging" and the "aging process" without coming to grips with a precise concept. We will try, in some of these instances to render unto Caesar what is Caesar's.

The following several paragraphs mention examples of situations where certain phenomena are understood to be related to chronologic age. Closer and more detailed observation of these instances indicates that the phenomena observed are related to other forces and not to the passage of time.

This discussion becomes important because it constitutes the general impression which tends to give weight to the concept in the minds of men that chronologic aging is associated with a certain amount of "degenerative" changes. In order to build more soundly the concepts offered by the Committee on Aging, one has to examine every idea that may offer support to the relationship of degenerative changes and "aging."

It is popularly believed that the study of the rings found in examination of trees indicated their chronologic age. This is essentially true except that the basis for these rings depends on many other factors rather than the passage of time. "Dendrochronology is the study of the chronological sequence of annual rings in trees and aged wood." (According to the *Encyclopedia Britannica*) Tree ring studies are possible because certain species produce growth rings during annual growing seasons. The width of the ring (the amount of growth) for each year is determined by certain internal (genetic, physiologic, and metabolic) and external (edaphic, biotic, and climatic) factors acting on the tree's metabolism. Time is not mentioned. Under normal conditions the internal factors and most of the external ones remain constant year after year. In widespread geographic areas where there is uniform variation in growth activity, resulting in uniform variance in ring widths, the cause of this uniformity is some widespread climatic factor which affects all trees in a similar fashion. In the United States Southwest, for example, tree growth is a reflection of the amount of rainfall. Trees growing in well drained soils rely solely on precipitation for soil moisture and in these locations the quantities of soil moisture is the result of how quickly the rain falls and of the amount of water lost through runoff and evaporation. A soil moisture history can thus be compiled by studying the relative ring width in any given tree growing in such a location. The growth rings in trees whose roots tap a permanent supply of soil moisture are too complacent for such an analysis."

The belief of the deer hunter in the relationship of the antlers to age, has been debunked by scientific studies. Nutrition and not age determines antler size. From this knowledge have come some immediate practical benefits for game management practices. One is the change of state hunting regulations to allow bagging bucks that have only spikes instead of full antlers. Formerly deemed underage, they are now seen as only undernourished. A considerable difference when it comes to evaluating herd densities and population trends.

THE TERM "AGING" and "aging process" gets interchangeably used in many medical articles with the term "degeneration." There is a growing concept that these terms need some definition and some separation. All too frequently the busy scientist when he arrives in the middle or end of his paper and has a few odds and ends that are unexplained, he sweeps them under the rug and says these things are due to the "aging process." More critical minds, however, are commencing to place these changes which are observed at any time in life in the proper category where they belong.

From one of the latest works in medicine dealing with the older patients, a book titled *"Clinical Features of the Older Patient"* by Joseph T. Freeman, we would like to quote several passages that indicate the tendency to recognize changes as being related to the proper etiologic factors and also to indicate that some other changes which are usually associated with the older individual are quite predominantly found in a younger age group.

Dr. Warren Andrew, on page 72 of the above-named textbook, says: "The characteristic of an aging muscular apparatus is the picture of an atrophy of disuse."

On page 91, Dr. Frederick T. Zugibe says: "The failure to date, to define biologic aging adequately resides in the controversey whether ostensible, morphological, bio-chemical or physiological changes are related primarily to senescence or to disease. For many years arteriosclerosis was believed to be a part of old age. More recent investigations have shown the invalidity of the thesis that a man is as old as his arteries. Some septugenarians and octogenarians have been found at autopsy to have coronary arteries relatively free of plaque formations, whereas individuals who die before the age of thirty have shown occlusive atheromatous lesions. Major William Enos, of the United States Army Medical Corps, revealed that about 77 percent of a group of American soldiers in their early twenties, who were killed in Korea, had atheromatous deposits in their coronary arteries. These were heavy in over 40 percent. Such observations are prima facia evidence that atherosclerosis is not an inevitable product of chronologic age alone, but the role of senescence, of course, is not precluded." Dr. Zugibe further states: "The earliest morphological alteration observed in human aortas, coronary arteries and cerebral arteries was a primary deposition of lipids. Lipid was first observed in the aortas of fetuses but was rarely observed in cerebral arteries before fifteen years of age. The lipid was absent in the coronary arteries of fetuses but made its advent the first few weeks after birth.

"IN A STUDY OF ALMOST 6000 cases, a peak in the incidence of arteriosclerosis was found somewhere around the onset of puberty, and appeared to advance more rapidly at this time than at any other time prior to forty years of age. It was noted that 20 percent of the surface areas that contained fatty streaks were converted into fibrous plaques. This occurred before the age of forty, and had taken about 15 years for conversion. The ultimate distribution of the fibrous plaque was in the same anatomical location as the fatty streaks in the younger age group. It was indicated that there are 15 years of life in which these

AUTHOR

Doctor Swartz, author of this article, presented this at an AMA Conference on Aging as chairman of the AMA Committee on Aging of the Council of Medical Service. He recognizes the contributions also of the committee members and the committee consultants.

lesions are of such nature that they can be readily reversed."

Dr. Andrew Fuller says, on page 109 of the same book: "The general management of elderly cardiac patients should differ little from that planned for younger individuals."

And, finally, in this incomplete list of instances where the weight of testimony indicates that age is probably not a factor in the production of any symptomotology or architectural change, we have the quotation from the latest book on emphysema and bronchitis, by Petty and Nette who say, simply: "Age itself does not damage the lungs."

I would like to ask each of you: How old are you? It doesn't matter whether you are 20 or 70. What part of you is 70 years old? You all know that in all living structures the cells are growing and changing and being decimated and destroyed and re-utilized. One doesn't have to take the body part by part, section by section, to discuss the living characteristics of cells, because in essence they are essentially the same. The only one I am not really sure of is the nerve cell. But to make this thing simple, the red cell in the adult human individual is supposed to have a life span of about 120 days. The other cell groups in the body probably vary to shorter or longer periods of time, but certainly none run for 20 years. What then, or what part of you, can thus be said to be as old as your chronologic years?

We don't expect, at this time, to have all or a part of the answers. We would merely like to raise in your mind some definite questions about some of the concepts that represent the past and present climates of opinion. We would ask you to be wary of the uncritical acceptance of terms such as degeneration, aging, and the aging process, and we would hope that you could become completely liberated from chronologic snobbery.

THE COMMITTEE ON Aging of the American Medical Association which has studied this whole area for some ten years, has come to the conclusion that they can find no disease entity or physical or mental condition that resulted from the passage of time. Nor was there any prophesied picture or condition that could reasonably be expected to occur in anyone after the passage of so much time.

Although the term geriatrics, which means the study of the diseases of aging, is used quite frequently, the Committee was unable to find any disease entity that was, of necessity, related to the passage of years or time. Arteriosclerotic heart disease, high blood pressure, and arthritis and cancer are found in the youngster; and measles, mumps, chickenpox and poliomyelitis and cancer are found in the oldster. The clinical picture under these circumstances varies only as the seed and the soil vary.

This complete breakdown of past philosophies leads us to pay serious heed to the results coming from recognized research laboratories. More and more it is indicated that the so-called degenerative diseases of man result from the impact of environment on that prefabricated hereditary structure that is man. In the laboratory we see these diseases that occur in animals exposed to hunger, extremes of temperature, lack of oxygen, infections, loss of blood, or fear, with little relationship to the age of the animal. In other laboratories the environment is regulated in the direction of protection for the individual from the effects of environment and we have members living for unbelievably long times.

THE CHRONIC CONDITIONS including the diseases and chronic illness and long-term care cases which constitute the major problems in medicine today, result from the recurring and irritating effects of environment over long periods of

time and are the results of these irritants and not the passage of time.

What must be added to this concept, which does not really come under the heading of recurring and irritating effects of environment, but does come under the less-than-ideal care, that the individual accords the castle in which he lives. The pot belly and flabby muscles that result from the lack of exercise, the loss of habits of study and forgetfulness that comes when the mind is not used, and the painful knees and flat feet that come from long-time pounding by too much weight, present a picture of dilapidation that represents long-time lack of care and is not due to the passage of the hours.

A few years back it was not uncommon to hear the physician say to the patient: "Well, what do you want, a new machine made from all these old parts?" This remark is rarely heard in our present-day medicine.

AGE IS NO BAR to good medical or surgical treatment, including open heart surgery, so long as the patient presents himself as a reasonably, physiologically functioning unit to the physician.

The medical and para-medical services, physician and para-physician personnel must begin to realize that something can be done for the diseases found among the oldsters. The days of condescension medicine to "grandpap" and "grandma" is at an end. The aging are people who are personalities and have names and should be recognized as such. The sense of being recognized and the sense of belonging are considerations that none of us can do without.

May we emphasize again, at this point, that many of the so-called infirmities of age stem directly from lack of conditioning. Great numbers of individuals, after leaving high school or college, settle down to a routine of bread winning which uses only a small portion of their muscular or physical equipment. Under these circumstances it is easy to understand why the physicial horizons become cramped, why the hand shakes, and why the gait becomes uncertain and tottery. This being true, it behooves the young and old to continue some type of physicial development and exercise throughout life instead of neglecting these important duties after leaving school.

Forgetfulness and mental retardation result largely from lack of attention and failure to concentrate, and loss of motivation. This can largely be prevented if we will all continue to encourage some habits of study learned in school. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits are sharpened only by proper physical exercise and mental activity.

OUR WHOLE PROGRAM, aimed at retarding the aging process, so-called, by improvement of physical and mental activity, would fall short of accomplishment if we did not at the same time strike a blow for moderation in the use of alcohol, tobacco and food.

Much propaganda must be directed to the already brainwashed oldster, and increasing efforts must be made to prevent the brainwashing of those coming behind him. The fatal concept that debilities come with age and at sixty-five one is over the hill, condemns the oldster to a period of ever narrowing horizons until the final sparks of living are the psychoneurotic concerns with the workings of his own body.

Aging is really living, growing and developing, so that the final days and contributions should be far different in the future than they seem to be today.

Further retarding of the "aging process" can be accomplished through other professions, through parents and teachers, all by selling some degree of self-discipline to the coming generations. This to such an extent that a program of physical exercise and good posture, daily mental exercise, not of the bread-and-butter kind, and careful regulation of body weight, become the principal rules of living. Add to this the protection of our present immunization program and cap this off with periodic health appraisal programs and the life expectancy figures should increase ten years in one generation.

IN CONCLUSION, we hope that we have shattered the present concept of an aging process. What we see instead is a hereditary package, buffeted by the wind and wave and weather of environment. This package is not like a sailless, rudderless ship. It is the most magnificent creation in the universe. Overlay this with emotional veneer which does not seem to be based on chemistry or physiology, but is equally capable of influencing the destiny, and you get some idea of a composite picture of Man, none of which is dependent on the "aging process," so-called.

The oldster, with his problems of health and disease, can look to the future with hope. The generally considered unchangeable, incurable, etiologic factor "aging process" has been eliminated. The oldster has become as treatable as any other age group and often responds as well.

Morituri Salutamus

But why, you ask me, should this tale be told
To men grown old, or who are growing old?
It is too late! Ah, nothing is too late
Till the tired heart shall cease to palpitate.
Cato learned Greek at 80; Sophocles
Wrote his grand *Oedipus,* and Simonides
Bore off the prize of verse of his compeers
When each had numbered more than fourscore years.
And Theoprastus, at fourscore and ten
Had but begun his *Characters of Men.*
Chaucer, at Woodstock, with the nightingales
At sixty wrote *The Canterbury Tales.*
Goethe, at Weimar, toiling to the last
Completed *Faust* when eighty years were past
For age is opportunity not less
Than youth itself, though in another dress
And as the evening twilight fades away
The sky is filled with stars — invisible by day.

MEDICAL MEMO

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MALARIA...

NOW KNOWN TO BE CARRIED BY A MOSQUITO, WAS THOUGHT TO BE CAUSED BY HOT WINDS FROM THE SOUTH WHEN IT STRUCK WISCONSIN IN 1830!

OTHER THEORIES BLAMED THE DISEASE ON MYSTERIOUS FUMES FROM NEW SOIL.

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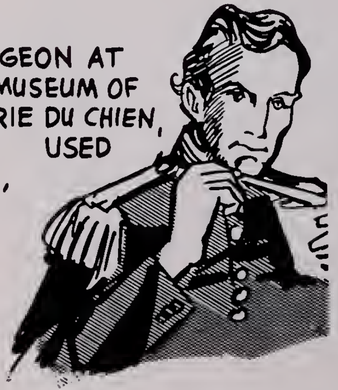

The Bulging Fontanelle Syndrome Following Tetracycline Administration

ABSTRACT: The administration of a tetracycline preparation in a five-month-old infant resulted in the development of a bulging fontanelle within the first twenty hours after the first dose. Although the mechanism for the increased intracranial pressure is not clear, there were no signs of serious central nervous system involvement. Withdrawal of the antibiotic resulted in rapid return of the fontanelle to normal.

BY SEYMOUR KREVSKY, M.D.

DETROIT

The clinical use of tetracyclines has become associated with a number of new entities, not the least of which is the "bulging fontanelle syndrome." Since its first description a decade ago, the relationship of the bulging fontanelle to the use of the drug has been more frequently reported. To emphasize the brief period of administration prior to onset and the rapidity of development, as well as the lack of any associated untoward reactions, this case is presented.

Report of Case

A five-month-old male infant was first observed by a physician because he had run a fever and been irritable for 36 hours.

The past history of the infant was well known, the child having been born in the hospital nursery. He was a slightly premature baby, weighing four pounds, ten ounces at birth.

At five weeks of age he was put on iron medication. Treatment was continued until he was 12 weeks old. Immunization with triple antigen (DPT) was begun, with a repeat dose 10 days before the onset of his present illness.

On initial examination the infant had a fever of 101.5 degrees and showed signs of a severe upper respiratory infection, although alertness was not impaired and suppleness of neck and back was not impaired. A throat culture and blood count were taken, and the child was put on an antibiotic preparation because of the severity of the reaction.

The antibiotic was a liquid preparation containing 125 mgms. tetracycline hydrochloride per 5 cc dose. The first dose was at one p.m. with repeat in six and twelve hours. Early the next morning he was again seen in consultation for reevaluation. The picture had now changed. Although fever was still present, as high as 101.4 degrees F., no resistance to neck or back suppleness was observed. Some irritability was present. The pharynx was slightly inflamed and ear drums showed no inflammatory changes. There were no rales, wheezes or rhonci present in lung fields. A soft systolic murmur was heard, without any arrhythmia. The most prominent finding, however, was a marked bulging of the anterior fontanelle. No prominence of the fontanelle had been present the day before, nor on any previous examination. The head circumference measurements were within the standard range for age.

Although an anemia of considerable severity was present, with a hemoglobin of 6.8 gms., the white blood cell count was not elevated, and there were on increases in the number of polymorphonuclears of lymphocytes. Skull x-rays were normal, as was a chest x-ray. Electroencephalogram was not abnormal. Spinal fluid examination was performed the following morning, at which time the bulging of the fontanelle had diminished to some degree. The spinal fluid showed a slight to moderate increase in pressure; but no cells. Culture after 48 hours was negative.

The child was taken off of the antibiotic immediately on admission to hospital. Improvement of

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his general condition progressed very readily. Fever subsided after 48 hours. Cheerfulness returned in 24 hours. The bulging of the fontanelle gradually subsided so that on the third day of hospitalization it was considered flat, and no increase in pressure has subsequently been reported. There has been no abnormal increase in head circumference size. The anemia was treated with parenteral iron and responded very rapidly. Physical and mental development have proceeded satisfactorily.

Comment

The development of intracranial hypertension in an infant manifested by a bulging fontanelle following the administration of a tetracycline compound has become fairly well known over the past decade as the use of these compounds has increased in the pediatric age group. In the effort to understand the basic pathogenic process involved a careful review of all reported cases is essential. Although there have been several comprehensive studies of the untoward reactions of the tetracyclines, the mechanism whereby intercranial hypertension is produced remains obscure. In this particular instance, as in previously reported cases, the dosage administered was low, well within the recommended safety margin; and the small number of doses, three, was sufficient unto itself to cause prompt return of the fontanelle to normal.

The question of whether to perform an immediate lumbar puncture in the presence of markedly increased intracranial pressure has been raised by several investigators. In our case it was decided to wait until the bulging showed signs of decreasing. Since the infant was crying the actual pressure was not measured.

Although a moderately severe anemia was present, which may have contributed to the development of the original infection, it did not contribute to the development of the cerebral hypertension. This could require further evaluation if similar cases showed a reciprocal relationship.

Summary

A five-month-old male infant with a severe upper respiratory infection and a very strong febrile response was treated with a tetracycline preparation. After three doses he developed a marked bulging of the fontanelle which could not be associated with the disease process. The withdrawal of the medication was followed by rapid return of the fontanelle to normal state. There has been no recurrence of similar difficulties with the infant. ☐

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Explains further Efforts to Improve State Mental Health Department

(Editor's Note: In this article, the Director of the Michigan Department of Mental Health reports on the downward trend in resident patient care. He also reviews the reasons for deficiencies in capacity to operate the state institutions. Doctor Anderson expresses hope for further significant program improvements and discusses in some detail five internal improvement objectives.—George W. Lowrey, M.D., Scientific Editor.)

BY WM. H. ANDERSON, M.D., DIRECTOR
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As a result of the introduction of modern psychotropic drugs, the extended use of family and nursing home care, and the increasing emphasis on early treatment at the community level, there has been a downward trend in the resident patient census in Michigan's state hospitals since 1957, matching a national trend.

Continued prosperity, higher mental health appropriations, and new ideas for delivering services have given rise to the hopeful anticipation of significant program improvements. Some have indeed occurred.

It is also true that Michigan is a progressive state that has always maintained better than average services for its citizens. Despite all of this, there are persistent and sometimes serious deficiencies in our capacity to operate the institutions of the Department of Mental Health—the eight state hospitals, seven state home and training schools, and other specialized facilities.

The reasons are not hard to find.

ALTHOUGH THE RESOURCES available to the Department are much greater than in 1957, the distribution has been uneven. In general, community mental health services and home and training schools for the retarded have received larger shares of the new money than other elements. At the same time, demand has risen in almost every category of service supplied by the state hospitals, except day-to-day care of the resident population.

Admissions, intensive treatment services, placement, after-care, and out patient treatment all reflect a greater workload, notwithstanding the availability of new and expanded community services. Furthermore, the increased expenditures to combat mental retardation went largely for expansion of the home and training schools rather than for improvements, except as they were incidental to the expansion.

THE STATE HOME and training schools and the state hospitals currently have equal difficulties in their efforts to maintain program quality. In fiscal 1967-68, neither group of institutions received a sufficient increase in appropriations to cover Civil Service pay increases, and both groups had to reduce employment levels. In addition, effective work by patients, which has always been an important factor in institutional economies, has been declining as a consequence of more effective treatment and discharge policies, leading either to loss of service or need for replacement by paid personnel.

Superimposed upon these considerations is an accumulation of miscellaneous problems resulting from chronic underfunding, coupled with residuals of outmoded systems of service delivery.

Much hope has been placed upon the ability of community mental health programs to assume a substantial share of the treatment responsibilities now carried by state facilities, thereby reinforcing the trends toward reduction in size and increase in efficiency of our institutions. Communities do not find it easy, however, to provide all the services necessary for the complete management of their mentally ill or retarded populations. In fact, it is not even possible in any organization model which does not provide for extended inpatient service.

When general hospitals furnish the inpatient element of community services, as they usually do, extended care is not economically feasible in most cases. The state will undoubtedly be required to continue to fulfill this need for the foreseeable future, but the number of beds that will be required has not been determined.

DESPITE THE FACT that state hospitals operate at a fraction of the cost of community hospitals, bed for bed, it is unlikely that significantly expanded budgets will ever be available to the state institutions. Not only is the magnitude of the requirement formidable, but there is no historical precedent or national example for adequate funding of public mental institutions.

There are also new factors in the health and welfare economy working against mental hospitals at both state and national levels. One of these, of course, is the diversion of mental health dollars to community services. This will prove to be a liability only if these services fail to fulfill their promise. Even larger sums are being drawn into non-psychiatric health, welfare and rehabilitation programs, some of which have federal matching provisions which discriminate against the state institutions. Their future, therefore, cannot safely be allowed to depend solely upon increased support.

Reductions in caseload combined with internal operating improvements seem to offer greater promise for upgrading the treatment programs. The correlative assumption is that no reduction in support will accompany the lessening of caseload.

SOME OF THE State Department's specific improvement objectives, oriented to the considerations outlined above, are the following:

I. Management improvements.
II. Data system improvements.
III. Clearer statements of objectives and standards, and refinement of program budgeting techniques.
IV. Continued acceleration of patient movement.
V. Further development of alternative methods of delivering psychiatric services.

Each of these is discussed briefly:

I. Management Improvements

Keeping up with technological advancements and finding better ways of doing things is a constant challenge in a large hospital system. The systems approach, which should be highly applicable, has characteristically encountered difficulty when applied to public service departments, particularly at the point of implementing recommendations. This, at least, has been the experience of the Department of Mental Health and it tends to be confirmed by others.

The apparent inability of public service departments to conduct and implement routine, systematic cost-effectiveness studies has been ascribed most frequently to the rigidities and resistances which characterize such departments, and to lack of top level support. This is tantamount to displacing the failure from the analyst to the system. In fact it may be viewed with equal logic as a deficiency in external design (i.e., the analyst's lack of appreciation in depth of the complexities and constraints of the organization.)

The Department of Mental Health hopes to overcome some of the difficulty by combining existing problem-solving resources in a single division independent of the operating divisions, and by giving approved projects top staff support. It is assumed that any recommendation for management improvement which does not have visible value to professional staff will encounter difficulties at the point of implementation in a hospital or home and training school. There must be close professional collaboration in all projects. Insistence on this should improve the design of our projects on one hand, and acceptability of results to operating staff on the other.

II. Data System Improvements

Modernization of the data system of the Department of Mental Health is needed for better clinical programming, as well as for management improvements. Current information inputs, although inadequate, exceed current processing capacity. The Legislature has previously appropriated money to study this problem. In 1968 the Department is requesting money for first stage implementation of its modernization plan.

III. Program Objectives, Standards, and Budgeting

Under the present state administration there has been a transition to a planning-programming-budgeting (PPB) system in which requests for money are based on plans to achieve specific functional objectives, rather than to support structural entities which tend to carry out loosely stated functions. Under a PPB system it is necessary to identify goals and provide descriptions of individual programs and to relate these to institutional and departmental goals.

An example of an individual program would be "growth and development" in which mentally retarded children with certain characteristics and potentials are carried through a sequence of very basic training activities leading to eligibility for more advanced programs. Although it may not be well known around the state, this system has contributed to some remarkable improvement in the institutions for the mentally retarded, and the same principles are being extended to the hospitals for the mentally ill. Unfortunately, money has not been obtained for all programs which are possible, so there are contrasts between institutions and between parts of institutions, but the method and the programs are available, subject to the availability of money.

In traditional medical programming, the tendency has been to group patients by diagnosis, age, place of origin, convenience of the responsible physician, or some other concept or combination which was unrelated or, at best, secondarily related to individual needs for treatment or training. Grouping by functional needs (as in intensive nursing or self-care units in general hospitals) is more compatible with good budgeting practice in addition to being a recognized means of achieving personnel economies and optimum utilization of skills. It is sometimes necessary to modify the degree of task specialization inherent in this concept in order to achieve some other desirable feature, such as continuity of care by a single treatment team.

The qualitative, and indirectly the quantitative, aspects of programs are controlled through the adoption of standards. This has been an apparent weakness of the Department of Mental Health. Its standards have tended to suffer erosion under the stress of inadequate financing and the demand for increased volume of services — conditions which usually exist. The restatement and enforcement of standards are certain to produce conflict at times, but are necessary to effect program improvements. These, combined with refinement of program statements for budget purposes and efforts to obtain more complete funding of existing programs, will hopefully be recognizable features of departmental activity in the immediate future.

IV. Acceleration of Patient Movement

Policies designed to prevent stagnation, institutionalization, and ineffective living are not new and they have not been unsuccessful. However, the massiveness of the problem is illustrated by the fact that there are still about 27,000 patients in Michigan state mental hospitals and home and training schools for the mentally retarded.

It is necessary to maintain an adequate level of domiciliary care for large numbers of chronic patients in addition to coping with a steadily increasing demand for intensive treatment services. To do this, programs must be broadly based to meet a variety of needs. It is intended to give priority to those elements which are highly restitutive or rehabilitative in nature as contrasted with those designed mainly to improve comfort or adjustment of patients within the institution. Building programs will emphasize maintenance and remodeling for alternative uses rather than expansion. There will be continuous, vigorous efforts to find other suitable homes for patients who do not need further hospitalization. Efforts will be made to recruit and reward staff on the basis of ability to produce dynamic programs.

V. Further Development of Alternatives

Assigning to state institutions those mental health responsibilities no one else wants is a weak approach to statewide programming. Not only does it fail to coordinate positively the efforts of state, community, and private sectors, but it also tends to retard desirable developments in community programs by seeming to render them unnecessary.

The role of state institutions must be actively delineated, just as are community and private roles. No one can say at this time exactly what the state role will ultimately be, but the responsibilities of the state would appear to be mainly for intermediate range treatment, long-term hospitalization of refractory cases, and participation in community plans where appropriate.

The principal existing alternative to care in state institutions is, of course, care in community facilities. Community programs must be strengthened. At the present time many of them have not made adequate provision for the care of very ill persons, nor are they working closely enough with state facilities to provide selected elements of care in a span of illness, for example, after-care following a period of treatment in a state hospital.

In some instances, Department Consultation Centers (out patient clinics for aftercare of patients discharged from state hospitals) are functioning in the same cities, in one instance in the same building, as state supported community clinics. It certainly will be a high priority objective of the Department of Mental Health to obtain a better delineation of roles than this implies and, within the framework of autonomy desired and needed by community boards, to achieve state-community coordination in the development of a unified mental health program for the state.

The Department is also working with several mental health related agencies to develop additional alternatives to institutional care, especially with the Department of Social Services and with the vocational rehabilitation and special education divisions in the Department of Education.

Summary

THESE ARE RATHER broad objectives, of course, and none of them will produce immediate or startling results.

An interesting feature of public mental hospitals is their tendency to look the same from one century to another. A number of writers have made a game of showing that we are still solving the same problems that people one hundred years ago thought were being successfully solved. Although psychiatry is far from a perfect science, and although important new discoveries may come at any time, the means are already at hand to do

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a far better job than we do. This suggests that the issues are at least as much political, economic, and social as they are medical.

Our immediate improvement objectives tend to emphasize techniques designed to cope with these non-medical limitations by maximizing efficiency and redistributing the workload in ways that should make it easier subsequently to follow-up with specific advancements in treatment, research, and training. Better care consistent with economic principles, but not economy per se, is, after all, our ultimate goal. □

Practical Management Of The Anovulatory Patient

ABSTRACT — Success is now anticipated in the treatment of the anovulatory patient whereas failure was the most likely prognosis in the past. This is primarily due to the availability of clomiphene citrate, an ovulatory stimulating drug. The release of clomiphene has made the accurate diagnosis of the cause of anovulation to be more pertinent; however, the close observation of the patient during treatment is mandatory.*

BY HARRISON C. VISSCHER, M.D.
ROBERT D. VISSCHER, M.D.
GRAND RAPIDS

The recent release of clomiphene citrate*, a drug to stimulate ovulation, is a real milestone in the successful therapy of the anovulatory patient.

Because of this success, there has been a renewed interest in the medical management of these patients. The purpose of this article is to present a practical approach in evaluating and managing anovulatory patients, using the diagnostic procedures that are economically feasible and are generally available throughout the state. With respect to clomiphene itself, our comments are based on reports already in the literature[1-7] and on our own experience in dealing with clomiphene as an investigational type drug from September 1965 through June 1967. During this time 26 patients were treated with clomiphene.

Results

The diagnosis pertaining to the cause of anovulation in these 26 patients are listed in **Table I.** Results of therapy in each diagnostic category are listed in **Table II.** There were four patients who were not married. One patient had had a previous tubal ligation but desired a diagnosis for amenorrhea and wanted to menstruate. One patient changed her mind during her diagnostic studies and desired to put off attempts at pregnancy. She was given clomiphene to confirm the diagnosis and prove the ability to be able to induce ovulation. Therefore, in this study we considered 20 patients eligible for pregnancy. Thirteen of these 20 patients became pregnant.

Complications occurred in two patients, one with ovarian dysfunction and one with androgenic adrenal hyperplasia. They both developed ovarian cysts larger than 10 cm. with moderately severe pain. The cyst and symptoms subsided spontaneously. Of interest is the fact that both had residues of previous salpino-oophoritis at the time of prior culdoscopy.

Discussion

Clomiphene is a synthetic drug taken orally which has the ability to stimulate ovulation in selected patients. The exact mechanism of action of this drug is not known in detail, but the most popular concept at this time is that clomiphene has an anti-estrogen effect. It seems that this anti-estrogen effect mediates itself through the hypothalmus and pituitary, causing a subsequent increase in pituitary gonadotropins which stimulate the ovary to produce hormones and ovulate. There is also some question as to whether or not clomiphene has a direct action upon the ovary itself.

Because clomiphene is related to other compounds that have significant adverse side effects, and because there are several important unan-

Table I. Results in 26 Patients Treated with Clomiphene

A. TOTAL PATIENTS	**26**
B. DIAGNOSIS	
1. Hypothalamic disease	3
2. Pituitary disease	1
3. Adrenal androgenic hyperplasia	4
4. Ovarian failure	1
5. Ovarian dysfunction including polycystic sclerotic ovaries	17
C. RESULTS	
1. Ovulation	
a. yes	20
b. no	4
c. uncertain	2
2. Patients eligible for pregnancy	20
3. Pregnancy	13
a. abortions	4
b. fetal death	0
c. liveborn	7
premature	0
mature	7
d. neonatal death	0
e. still pregnant	2
4. Complications	
a. ovarian cyst with pain	2
b. multiple pregnancy	0

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* Clomiphene citrate used in this study was obtained as Clomid from the Wm. S. Merrell Company, Cincinnati, Ohio.

Table II. Results in Treatment of 26 Patients with Anovulation

DIAGNOSIS	NO. OF PATIENTS	OVULATED	PATIENTS ELIGIBLE FOR PREGNANCY	PREGNANCY
Hypothalamic	3	0	1	0
Pituitary	1	0	1	0
Adrenal	4	4	3	3
Ovarian Failure	1	0	1	0
Ovarian Dysfunction	17	16	14	10

swered questions regarding the use of clomiphene, it is generally agreed that this drug has to be used with caution. Judicious selection of patients with close follow-up is mandatory. The William S. Merrell Company which synthesizes the drug, lists only one approved indication for use at this time. They state that clomiphene is indicated for the treatment of ovulatory failure in patients desiring pregnancy under certain circumstances.

Anovulation is not a specific disease entity; it has many causes, some of which are significant, and should be diagnosed and treated specifically.

THEREFORE, HOW DOES one astutely pick out the patients who will most likely respond successfully to clomiphene, and still not miss other significant diseases that should be handled in a different way? Our purpose, then, is to present a practical approach to the proper selection of such patients for clomiphene therapy.

These patients usually present themselves to the physician because of infertility or secondary amenorrhea. **Figure I.** gives an outline of our approach to these patients. In order to prove anovulation, consider its etiology, and select those patients best suited for therapy, we feel that the physician should obviously take a good history and do a complete physical examination. This history and physical should be endocrine oriented, and attempts should be made to rule out constitutional and systemic diseases. Pregnancy must be ruled out in any patient with amenorrhea in the child bearing age.

The patient should keep a basal body temperature chart for at least two or three months, with an endometrial biopsy done on the appropriate day. If the patient is menstruating, we prefer that the biopsy be done on the 24th day of her cycle. A vaginal smear in the absence of vaginitis is helpful for hormonal evaluation and can also be useful in determining the presence of Barr bodies or chromatin bodies. A routine cervical and endocervical cancer detection smear is also important, especially if abnormal bleeding is present. Examination of the cervical mucous for amount, viscosity, clearness, and ferning is useful in evaluating ovarian function. Serial evaluation of vaginal smears and cervical mucous could be even more meaningful.

Clomiphene is primarily useful in patients with adequate endogeneous estrogen. In this regard, the most useful clinical test for us has been the progesterone withdrawal test. A pure type of proges-

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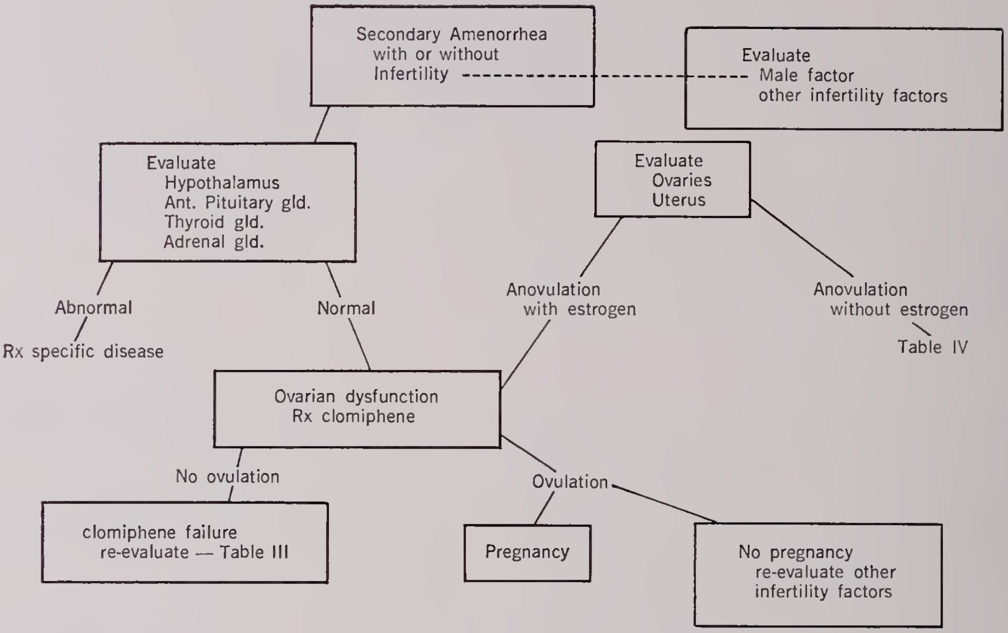
Secondary Amenorrhea with or without Infertility
Evaluate Male factor other infertility factors
Evaluate Hypothalamus Ant. Pituitary gld. Thyroid gld. Adrenal gld.
Evaluate Ovaries Uterus
Abnormal
Rx specific disease
Normal
Anovulation with estrogen
Anovulation without estrogen
Table IV
Ovarian dysfunction Rx clomiphene
No ovulation
clomiphene failure re-evaluate — Table III
Ovulation
Pregnancy
No pregnancy re-evaluate other infertility factors

Fig. 1 — Outline for diagnosing anovulation and its causes

terone must be used. We use oral medroxy progesterone acetate 10 mgm.* per day for five days, and expect withdrawal bleeding two to four days after stopping the progesterone. As previously mentioned, the vaginal smear and endometrial biopsy also help in evaluating the endogeneous estrogen level. Other basic tests that we use are: an examination of the visual fields, PBI, and a 24 hour urine for 17 ketosteroids and pituitary gonadotropins.

In addition to the history and physical examination, these tests serve as screening procedures to rule out gross abnormalities of the hypothalamus, anterior pituitary, thyroid, and adrenal gland as possible sources of anovulation.

IF INFERTILITY IS part of the problem, it is important that the male partner be judged fertile by doing a urologic examination and semen analysis. A Huhner (post coital cervical mucous evaluation) test and tubal patency test should also be performed in the infertile female.

If all the above tests are normal, except those indicating anovulation, i.e., basal body temperature chart, endometrial biopsy, vaginal smear and cervical mucous, then the patient is an excellent candidate for clomiphene therapy. There is some rational for inducing uterine bleeding before starting clomiphene or not attempting pregnancy until the second induced ovulation. The starting dose is 50 mgm. per day for five days starting on the fifth day of the cycle. If after the first month, the patient does not respond, then the dose is increased to 100 mgm. per day for five days. The patient must be followed closely, using the basal body temperature chart and a monthly pelvic examination immediately before the next dose of clomiphene is started. The minimum time between doses should be 30 days. If the basal body temperature chart shows a temperature elevation, the next dose should not be given until it drops, the woman menstruates, or pregnancy is ruled out. If clomiphene is going to work, it usually does so within three cycles of therapy, frequently working the first treatment cycle.

Of course, pregnancy is the ultimate in proving an ovulatory response. But short of this, the use of the basal body temperature chart and the endometrial biopsy is the most practical means of evaluating success in inducing ovulation. If clomiphene does not stimulate ovulation, then the patient is classified as a clomiphene failure, and another course of action must be instituted.

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* Provera — Upjohn

THE MOST COMMON side effects with clomiphene therapy are ovarian cysts, lower abdominal discomfort with bloating secondary to ovulation, hot flashes, blurring of vision, and nausea. The higher the dose used and the larger the ovary to start with, the more likely one is to get overstimulation and ovarian cyst formation. This is one of the reasons that a pelvic examination must precede any repeated course of therapy. If the ovaries are enlarged, no further clomiphene should be given until they recede in size, and then the dose should be reduced. One should be careful not to overtreat these patients with enlarged ovaries. Surgery should only be performed if the patient develops an acute surgical abdomen along with an ovarian tumor.

As with other ovulatory drugs, the incidence of multiple pregnancy increases with clomiphene therapy. Approximately 10 to 12% of the patients who become pregnant will have a multiple pregnancy. Pregnancy itself is actually a contraindication to the use of clomiphene. Although no adverse effects have been demonstrated on the human fetus, there has been some animal evidence to suggest such, and therefore this potential problem has to be further evaluated.

With those patients who do not respond to clomiphene, further investigation should be carried on. The first step with clomiphene failures is to thoroughly re-evaluate the patient.[7] **Table III** lists items to be emphasized when re-evaluating these patients. The physician must consider the possibility that he may have the wrong diagnosis. Rather than ovarian dysfunction, he might have a hypothalamic, pituitary, thyroid, or adrenal problem. Ovarian failure or dysgenesis are other possible diagnoses. In order to further evaluate the patient, other tests are in order, some of which are not always readily available. If the indicated tests are not available to the physician, he should consider referring the patient.

One of the tests indicated would be an evaluation of the pituitary gonadotropins, FSH and LH. The newer immunologic methods of evaluating LH are becoming more reliable and available. These can be helpful in differentiating between a pituitary abnormality and ovarian failure. Skull X-rays and pneumoencephalograms may be needed to rule out central nervous system disease.

CULDOSCOPY IS ALSO very helpful in these patients if it has not been done previously. It is a good means of visually evaluating the ovaries and checking for pelvic adhesions and other diseases of the uterus, tubes, and ovaries which may interfere with reproduction. If the patient has primary amenorrhea, or a possibility of ovarian dysgenesis, chromatin and chromosome studies should be instituted. Recently, it has been shown that some patients with secondary amenorrhea can also have chromosome abnormalities of a mosaic type.[8] The above studies should more clearly

Table III. Evaluating Clomiphene Failures

A. Re-evaluate history and physical
B. Pituitary gonadotropins
C. Skull X-ray
D. Visual fields
E. Culdoscopy
F. Adrenal gland evaluation
    1. Dexamethasone suppression test
    2. ACTH stimulation test
    3. Metopirone test
    4. Plasma cortisol
    5. Electrolytes, GTT, etc.
G. Consider neurological consultation
    1. Pneumoencephalogram
    2. Arteriogram
    3. EEG
H. Chromatin
I. Chromosomes (karyo-typing)

Table IV. Evaluating Higher Areas Affecting Ovulation

A. INDICATIONS
    1. Anovulation without endogenous estrogen
    2. Atrophic vaginal smear
    3. Atrophic endometrium
    4. No progesterone withdrawal bleeding
    5. Clomiphene failures
B. PROCEDURE
    1. Pituitary gonadotropins
        a. Method
            1) Bio assay
                24 hour urine
            2) Immuno assay
                24 hour urine
                serum
        b. Results
            1) High FSH — ovarian failure
            2) Low FSH — hypothalamic — pituitary disease
                skull X-ray
                visual fields
                neurological consultation
                psychiatric evaluation
        c. Treatment
            1) Ovarian failure — sequential estrogen and progesterone
            2) Hypothalamic anovulation — clomiphene and human chorionic gonadotropin
            3) Pituitary anovulation — human pituitary gonadotropin and human chorionic gonadotropin
            4) Treat specific findings — tumors, etc.

define the etiology of the amenorrhea so that one can be more specific in management.

There are certain problems that deserve comment that might be encountered in the original patient work-up, as described above. **Table IV** is an outline of how we evaluate higher areas having an effect on ovulation. If there is evidence of a low estrogen level, such as: no withdrawal bleeding after progesterone therapy, an atrophic smear, atrophic endometrium, or physical evidence of genital atrophy, then further testing is indicated to give the cause. A 24 hour urine for estrogens would be confirmatory. If the pituitary gonadotropins in a 24-hour urine are elevated, it would indicate ovarian failure. At the present time, there is no known successful treatment of ovarian failure when considering ovulation. However, sequential therapy with an estrogen and progesterone can be quite helpful in producing regular menses for these patients and may have metabolic significance.

IF THE PITUITARY gonadotropin test is low, it points to a hypothalamic or pituitary problem. Here skull X-rays, peripheral fields, pneumoencephalograms, a good history, and further neurological evaluation will differentiate the two. Clomiphene is of no value in the treatment of pituitary failure. However, human pituitary gonadotropins along with the use of human chorionic gonadotropin have been quite successful in inducing ovulation in these patients.[9-10] But human pituitary gonadotropin is not generally available. So these patients should be referred to a center for this treatment. Clomiphene can be used in treating hypothalamic causes of anovulation. In this instance, the treatment consists of larger doses followed by the use of the human chorionic gonadotropin. This program has met with success in approximately two-thirds of the patients on whom it has been used.[9]

If the 17 ketosteroids are elevated, then it is necessary to evaluate the adrenal gland. Adrenal suppression tests with dexamethasone* following the 17 ketosteroids and the 17 hydroxycorticosteroids should be used to diagnose adrenal hyperplasias, adrenal genital syndrome, and adrenal tumors, benign or malignant. The specific treatment of these diseases can be very helpful in inducing ovulation. If the 17 ketosteroids are slightly elevated, and if they depress with the dexamethasone suppression test, a trial of cortisone can be very helpful in inducing ovulation. One must be aware, however, that success may not be evident for several months, and if the patient does not respond to cortisone, then clomiphene is the drug of choice. Consideration also must be given to the fact that with polycystic sclerotic ovaries the 17 ketosteroids can be slightly elevated.

Summary

In summary, the drug clomiphene which recently became available, has stimulated renewed interest in the treatment of anovulatory patients. The success is refreshing because it is the first time that a specific ovulatory stimulating drug has been made available. However, it must be used with care, and cautious follow-up of the patient is mandatory. The availability of this drug should also stimulate the physician to better diagnose the cause of the patient's anovulation and to continue the search for a specific diagnosis if clomiphene should not work. □

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* Decadron — Merck, Sharp and Dohme

Insulin Lipodystrophy

This is the first of a series of brief comments concerning problems seen in patients with diabetes mellitus. Members of the Clinical Society of the Michigan Diabetes Association will be supplying this material at frequent intervals. Readers of this Journal who care for diabetic patients will benefit by looking for these presentations of clinical importance and usefulness. — George Lowrey, M.D., Scientific Editor.

BY GEORGE C. THOSTESON, M.D.
DETROIT

Insulin can be disfiguring.

It is not generally realized that a distortion of subcutaneous fat may occur in as many as thirty to forty percent of diabetics taking insulin.

The condition is not serious in that no vital structures are involved but it does create great psychological problems, particularly in females. Insulin lipodystrophy may assume two forms: Lipohypertrophy occurs when a hive-like mass results from the too-frequent injections of insulin into one area; lipoatrophy appears like a saucerization of the tissue, usually occurring at any site of injection. The latter is more common and more disfiguring. It becomes apparent after six months of insulin therapy.

Strangely enough, the occurrence of lipoatrophy occurs primarily in females (young and old) and in little boys. In my experience, it is rare in adult males except in patients with hemachromatosis.

THE CAUSE OF lipoatrophy is not clear. Factors that have been considered include: Trauma from the injection, cold insulin, allergy to insulin, presence of fat splitting ferments in the insulin, preservatives in the insulin (tricresols), protamine zinc, androgens (lack of it predisposing females and young males), and impurities in the insulin. However, none of these factors have been found consistently in all cases.

Based on some of the suppositions as to cause, certain recommendations can be made. Insulin can be kept at room temperature. The currently used ampoule of insulin will not deteriorate at a greater than average rate if not refrigerated. Smaller gauge, longer needles should be tried allowing for a deeper, less traumatic injection. Variation of the site of injection may help. While the arms and legs are the usual sites, the abdomen and buttocks should also be used. In patients with widespread atrophy, it may be difficult to find an area uninvolved. In this instance improvement has been reported by Collens and associates,[1] by continuing to inject the insulin in the atrophic area.

A smaller volume of insulin may be tried by changing from U-40 to U-80 strength. In one case I have advised U-500 insulin measured in a tuberculin syringe and given twice daily. Changing brands of insulin has no effect. Changing to an insulin free from protamine zinc should be considered; globin or the lente group may help.

Gold[2] has injected sterilized coconut oil into the atrophic areas. Improvement was maintained for as long as two and one-half years after treatment.

Changing from beef-pork insulin to pork insulin may help in some instances.

IN SOME INSTANCES lipoatrophy will correct itself in a matter of years. This is little consolation to the woman who is upset by the defect and unable to wear certain summer clothes, shorts or a bathing suit. Lessening of the atrophy tends to occur with gain in weight. This may not be desirable from the medical standpoint nor from woman's sense of vanity.

Lipohypertrophy usually subsides by avoiding injections in the site involved. In my experience, lipohypertrophy can alter diabetic control by reason of faulty insulin absorption. Lipoatrophy does not seem to affect diabetic control. Paley[3] found no change in the stability of diabetic control with this condition.

It is essential to check the sites of insulin injection periodically to determine the presence of lipodystrophy. The thighs should be checked with the legs straight in order to obtain the proper contour. Many women assume a posed position when the legs are examined. This alters the contour of the limb and early changes may not be evident. The arms should be checked in dependent positions to get proper contour of the upper portions where insulin is usually given.

Attempts by the author to control the diabetes of these patients with oral hypoglycemic agents

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Doctor Thompson, the author, is attending physician at Harper Hospital, Detroit.

have not been successful. Usually these patients with lipodystrophy are young with a moderately severe to severe type of diabetes. Such types are generally not amenable to oral agents either initially or after insulin has been tried.

Summary

Insulin lipodystrophy is a complication of insulin therapy. Lipoatrophy is particularly disturbing because of disfigurement and attendant psychological effects. The cause of lipoatrophy is not known.

Patients taking insulin should be examined periodically for signs of subcutaneous fatty changes. ☐

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Report of Curriculum Study Committee, Wayne State University School of Medicine

The Curriculum Study Committee was appointed in 1963 by Gordon H. Scott, Ph.D., then Dean of the School of Medicine of Wayne State University and now Vice President in Charge of Medical School Development. The Committee was re-appointed by Dean Ernest Gardner, M.D., and with some changes in membership has continued its studies since that time. It was directed to study the curriculum of Wayne State University School of Medicine and make recommendations with a view to meeting the rapidly evolving needs of medical education in a highly sophisticated technological society.

In recent years, the commitments of the University to the State of Michigan led to the expansion of the student body from 65 to 125 per class, and by 1970 the student body will have further increased to 200-250 students per class. Moreover, in 1970, the School of Medicine will move to a new location in a medical center which will include a basic science building that will house multidisciplinary laboratories for the preclinical departments.

In addition to a new medical research building which is already extant, within a few years, the campus will include a new medical library, clinical facilities consisting of a university outpatient building to service all inpatient facilities in the medical center, a children's hospital with 325 beds and teaching and research facilities for children, the Webber-Harper Hospital with approximately 500 teaching beds, the Grace Hospital, the Hutzel Hospital, primarily a maternity hospital with additional facilities for general medical and surgical care, a projected veterans' administration hospital and possibly a new Detroit General Hospital. The Sinai Hospital, an affiliated institution, provides additional well-supervised teaching facilities. The Lafayette Clinic, a state-owned institution, and the psychiatric division of the Herman Kiefer Hospital provide psychiatric facilities.

THE CURRICULUM TO be designated should take into account rapid alterations in the practice of medicine that may be expected within the next decade. The School of Medicine as part of an urban university must prepare for the rapid changes in medical services to be implemented under recently enacted federal legislation that will produce extensive change in systems of delivery of medical care. It must also expect increasing participation by the student body in planning for the educational process to which it is committed. It has become increasingly clear that students in institutions of higher education have become more concerned with the quality of education, medical or otherwise. This we view as a healthy development to be encouraged and fostered.

The Flexner Report published in 1910 precipitated changes in medical education that provided a firm foundation for science in medical education. The extensive and universal development of basic science in medical education was the direct result of this report. The radical changes that are now appearing in medical education and in the practice of medicine are attested to by two of the most significant reports that have appeared in almost half a century, the Coggeshall Report, *Planning for Medical Progress Through Education* published in 1965 and the Millis Report, *The Graduate Education of Physicians* published in 1966. Both reports have emphasized the importance of revision in the medical curriculum.

To quote from the Coggeshall Report, "The medical curriculum currently needs reconsideration, re-evaluation, and revision. The vast accumulation of new knowledge makes it increasingly evident that not all medical information available can be conveyed in four years. There is need to develop a curriculum that provides for later specialization. There is need for re-examination of the curriculum to eliminate both duplication and subject matter not essential to subsequent education and practice. There is a particular need to encourage (medical schools) to give more intensive attention to curriculum evaluation . . . and that more intensified work leading to curriculum improvement be considered. The work undertaken by the association (American Association of Medical Colleges) might include (1) further stimulation of experiments in curricula to adapt to new knowledge, new practices, and new technologies; (2) further efforts to develop better length and sequence to curricula; (3) comparative analysis of results of different curricula; (4) increased exchange of information and discussion about new and revised curricula."

THE MILLIS REPORT states that "because educational programs properly differ from one institution to another, we recommend that each medical school faculty and each teaching hospital staff acting as a corporate body explicitly formulate and periodically revise their own educational goals and curricula. To do so would be a healthy exercise for medical educators and a fundamental step toward the solution of many of the educational problems." The Report proposes certain general goals that need emphasis now. Under educational goals, it recommends that (1) "medical schools and teaching hospitals should prepare many more physicians than now exist who will have the desire and qualifications to render comprehensive, continuing health services, including preventive measures, early diagnosis, rehabilitation, and supportive therapy, as well as the diagnosis and treatment of acute or episodic disease states. (2) No physician, by himself, has all of the knowledge and skills necessary to provide all of his patients with optimal health care. Specialization implies division of responsibility. But the patient is undivided. Programs of graduate medical education should, therefore give greater emphasis to the training of physicians for cooperative effort — among medical specialists and with members of other health professions — in order that each patient may be provided with the combination of skills and knowledge best adapted to his particular needs."

The Coggeshall Report also states that "the important question for the future is whether the present system is sufficiently flexible and imaginative to keep pace with the contemporary revolution in medical science and the changing expectations of the people of America. Specifically, in an era when the concern of society is turning from the protection of the interest of the individual practitioner to finding ways of meeting the aggregate health care needs and expectations of the people of America, the question arises whether new approaches to the education of physicians are not now called for."

CURRICULAR REVISIONS must take into account the following needs stated in the report:

(1) **Need To Devote Increasing Attention To The Requirements Of The Nation.** This need is highlighted by trends toward population growth and change, increasing individual health expectations, increasing effective demand for health care, increasing specialization, need for more physicians and health personnel, and the expanding role of government — virtually all major trends that have been noted. Clearly, the publicly supported medical schools have greater responsibility to orient their efforts toward meeting requirements of their sponsoring states." . . . the need of the future will be for the field of medical education to assume responsibility for meeting the quantitative as well as the qualitative needs of the nation and individual states and communties. . . . increasingly, society is looking to the medical profession to assume responsibility for providing the health care that the scientific advances have made possible and for which members of society desire to pay. . . . Those responsible for medical education — faculty members, deans, university officials, trustees, and legislators — will, in decades ahead, need to devote careful attention to appraising the needs of society for health care and health personnel

and to developing and implementing plans to meet those needs.

(2) Need For More and Better Prepared Physicians. Some factors appear more important to effective instruction than the size of enrollment alone. First, there clearly must be a faculty of adequate size, diversity, and qualifications to serve the school's enrollment. All too often, as a school has increased its enrollment, it has not expanded its faculty and facilities in keeping with the greater instructional tasks assumed. Hence, too limited faculty and facilities have impaired instruction — even though the 'size' of the school has most often been criticized as the cause of a decline in instructional quality. Second, the way instruction is organized will affect how well a school can serve a larger enrollment. On the one hand, adding students without changing the way instruction is organized may well impair the quality of instruction. On the other hand, it is entirely likely that new ways of organizing instruction may overcome traditionally anticipated problems of size and open new possibilities not previously contemplated.

(3) Need For More Persons For Related Health Professions And Occupations. The role of the medical school in the years ahead should be that of seeing that persons needed for related health professions and occupations are trained, that training is appropriate, and that they are trained to participate effectively in the physician-led health care team. The medical school should not, of course, have to assume direct responsibility for their education.

(4) Need To Improve Delivery Of Health Services. The field of medical education needs to turn its attention to the matter of improved delivery of health services in three ways. First, those in the field of medical education themselves need to devote greater attention to studying how health care can best be provided. Second, they need to teach medical students and young physicians to provide health care in the ways that are most effective medically and efficient economically. Third, the medical school of the future can contribute significantly to the health field by providing the 'model' for 'demonstration' of how health care can best be delivered.

Schools of medicine should be taking the lead in studying the ways medical care is delivered to patients. Their concern should be not only with acute care but also with preventive care and rehabilitative care. Their concern should be with comprehensive family care as well as with specialty care. The university-sponsored medical school is in an unequalled position to draw on the resources of many disciplines — medical practice, economics, business administration, sociology, psychology, education, engineering, and others — to study the way in which comprehensive health care is provided. The need is for careful study of how health care can best be made available including how medicine can best be practiced — and for the development of more effective plans of organization and delivery of health care.

(5) Need To View Medical Attention As A Continuum. Although some schools are doing some planning, there are too few. Those that do are

Editor's Note: This WSU Curriculum Study Committee report is printed because it is believed that many MSMS members will be interested. The report has been approved in principle by the entire medical school, but not all the changes have been incorporated as yet into the curriculum. The Curriculum Study Committee was comprised of Ruben Meyer, M.D., Chairman, Harry Maisel, M.D., Secretary, Donald J. Birmingham, M.D., Lawrence Powers, M.D., Barbara F. Rosenberg, M.D., Kenneth Pitts, M.D., Alexander J. Walt, M.D., Lawrence M. Weiner, M.D., and Joseph Hess, M.D.

doing too little; the need for planning can be expected to increase rather than decrease in the future.

The educational needs of the physician should be re-evaluated, toward the goal of defining the subject matter which should be included in the curriculum. It should be recognized that the physician can no longer master all areas of the basic biomedical sciences — he cannot even be acquainted with all of them. Nor can he be competent in all technologies associated with his own specialty. He must be increasingly dependent upon personnel trained in related fields. The education of a physician must more and more include management and *problem solving rather than encyclopedic capacity*. No longer is the individual physician with his personal armamentarium of knowledge and tools, the patient's sole resource. The physician must now assume the role of team leader having the broad familiarity and competence to marshal the appropriate expertise and resources beyond his individual skill. This ability to use technical assistance and to work cooperatively in a team should be the essence of professionalism. Basic principles required for intelligent decision making should compose the curriculum, with emphasis placed on problem solving and the use of human and technological resources.

(6) Need To Maintain Interdisciplinary Relationships And Relationships Between Research And Instruction. Prevailing trends imply clearly that a dynamic relationship will need to be maintained permanently between research and instruction.

Closer ties among the sciences and closer ties — virtual identity — between research and instruction highlight the need for further development of the relationship between the medical school and the university emphasized by Flexner a half-century ago.

(7) Need For The University To Assume Increasing Responsibility For Medical Education. Curricula should be interwoven to provide a community of mutual understanding among all health-oriented disciplines, and the programs of each specialty should include direct experience in how to function as a member of a cooperative team.

The educational obligations of the School of Medicine must be assumed by the medical faculty and a system of educational goals should be designed to meet its educational responsibilities. Appropriate evaluation procedures will have to be established to test the effectiveness of the system.

The faculty of the School of Medicine must clearly understand that the student is the prime subject of its educational efforts. The entering student is strongly motivated to become a physician with a desire to help others and be of service to society but is frequently converted to a frustrated individual.

Local Problems

Some of the problems of the current teaching program at our School of Medicine are as follows:

(1) The curriculum is inflexible. Every student must tread the same mill in its entirety.

(2) The curriculum is largely uncoordinated with respect to individual disciplines, and between basic sciences and clinical medicine.

(3) Teaching is often academically unrewarding to the faculty and secondary to research needs; this frequently leads to inadequate teaching.

(4) Basic science departments often fail to consider the goals of their teaching programs with respect to the student's motivation of becoming a physician. Instruction is frequently "all-encompassing," a cramming of newer knowledge into the same hour of instruction without the pruning of older material. It appears that instructors are at times afraid to entrust students with the process of self-learning, but endeavor to cover all aspects of a subject.

(5) There is a minimum of patient contact in the first two years.

(6) Little, if any, time is spent on remedial exercises for students with learning problems. The drop-out rate at medical school represents an important wastage of manpower and money, and is often the result of a student's poor "cramming" technique rather than lack of intelligence.

(7) Examinations are held so often and in such a manner that they lead to an inhibition of independent thinking and scholarship.

To remedy these defects the Curriculum Study Committee proposes that the medical school *should, in its primary function of training physicians, provide an educational experience that*

(1) Encourages scholarship and independent thinking and leads to the acquisition of a scientific attitude and the habit of continuing self-education;

(2) Furthers the motivation of entering students to be of service to man and society; and

(3) Is flexible to meet the needs of individual students. These needs arise from differences in student background, interests, and choice of future medical careers.

These aims can be accomplished by:

(1) Teaching a "core curriculum" in the basic science by an interdisciplinary method, and using an organ system approach.

(2) Implementing a core clinical experience, with greater interdepartmental participation.

(3) Introducing elective courses.

(4) Providing adequate free time for independent study.

(5) Introducing correlative clinics in the first year to emphasize the relevance of the basic sciences to clinical medicine.

(6) Commencing instruction in the technique of history taking and physical examination from the beginning of the second year.

(7) Indicating the relevance of behavioral science and socio-economic factors to health and disease.

(8) Providing individual student counselling, and

(9) Consideration of an honors program for gifted students.

"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."

—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs

MSMS ANNUAL SESSION, SEPT. 25-26-27

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House of Delegates, Sept. 22-23-24

A Progress Report: The Michigan Community Health Services Study

BY ANNA B. BROWN, PH.D.

AND VLADO A. GETTING, M.D., DR.P.H.

ANN ARBOR

Do committee reports on health problems result in action or gather dust on a shelf?

The Committee of Forty of the Michigan Community Health Services Study[1] believes that action can result from study reports and began exploring the opportunities and possibilities at their March, 1968, meeting at Fair Lane Conference Center, University of Michigan Dearborn Campus.

During June and July, the Study's six Regional Task Forces on Community Health Services will meet to review the Committee of Forty report of recommendations, and to determine priorities for implementation based on this report and on their own regional reports.

THE STUDY DEMONSTRATES that concerned citizens, community leaders, are interested in health services and facilities. They can and will work with health professionals in order to effect the improvement of health services in Michigan. The reports of recommendations are one step in this process; implementation of the recommendations is another step.

Among the recommendations covering a broad spectrum of problems, are areas of current interest and concern to medical societies; for example,

1. *Codification of all health laws, rules and regulations,*
2. *Provision of emergency mental health services,*
3. *Determination of need and development of drug addiction programs,*
4. *Treatment and rehabilitation of alcoholic patients,*
5. *Provisions for ambulance service,*
6. *Improvement of health instruction in the Michigan school systems,*
7. *Communication of health services and resources to practitioners and consumers, and many others.*

The reports and the forthcoming meetings are a culmination of four years of effort of 246 community leaders who were members of the six regional task forces and the statewide committee. These leaders identified public health programs, consulted with experts, reviewed resources and existing programs, considered alternative solutions, and then developed recommendations for the improvement of community health services. Each of the six task forces prepared a report. These reports were then reviewed and together with its own recommendations, consolidated into a single report[2] by the statewide committee.

THE INVOLVEMENT OF community leaders began in 1963 when the Michigan Community Health Services Study was initiated under the sponsorship of the Department of Community Health Services of the School of Public Health of the University of Michigan; the Michigan Department of Public Health; and the Michigan Health Officers Association. Representatives of the sponsors shared a growing concern that community health needs were not being adequately met by traditional patterns of organization and financing. Out of their concerns, the plan for the Study evolved and was financed by grants from the W.K. Kellogg Foundation and the United States Public Health Service.[3] Operationally, representatives of the sponsors formed a group, the Research Policy Committee, to give direction and guidance to the work.

The State was divided into six regions taking into consideration: 1) health department boundaries, 2) hospital service areas, 3) trade centers, 4) travel patterns, 5) natural geographic boundaries, etc. Each region was composed of several counties (7 to 28) and a population ranging from

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TABLE I

CHARACTERISTICS OF REGIONS IN THE STUDY

	REGION	NUMBER OF COUNTIES	POPULATION	PER CENT STATE POPULATION
I	Upper Peninsula	15	305,952	3.9
II	Northern Michigan	28	355,614	4.5
III	Southwestern Michigan	9	1,148,552	14.7
IV	Central Michigan	10	760,367	9.7
V	Detroit-Southeastern Michigan	7	4,181,384	53.5
VI	Saginaw Valley-Eastern Michigan	14	1,071,355	13.7
	Total	83	7,823,194	100%

305,952 in the Upper Peninsula, Region I, to 4,181,384 in Southeastern Michigan, Region V. **(See Table I)**

Community leaders in each of the 83 counties and for the whole state were identified using an adaptation of the methodology employed by the National Commission on Community Health Services.[4, 5]

Briefly, one questionnaire was mailed to the health officers, or the public health nurse or sanitarian if there was no health officer. Another questionnaire was then sent to certain positionals in each county, i.e., persons holding various positions in sectors of society such as the president of a large bank, the president of the local medical society, the editor of the largest newspaper, the superintendent of schools, and so on. Positionals and health officials were asked to complete the questionnaire by identifying: 1) persons who had been involved in decisions on community issues such as annexations, civil rights, fluoridation, local income tax proposals, etc.; and 2) those individuals who were considered to be persons of general influence. The nominees, resulting from the analysis of questionnaires, were classified into sixteen sectors of society such as physicians, businessmen, bankers, labor leaders, educators women's groups, mass media. **(See Table II)**

From the resulting listings, according to predetermined scoring techniques, approximately 75 percent of the membership of each task force was selected. Representatives of the three sponsors and local health officers, using their knowledge of persons in the region, selected the remaining 25 percent of the task force members. The latter group was added to assure both geographical and occupational representation.

TABLE II

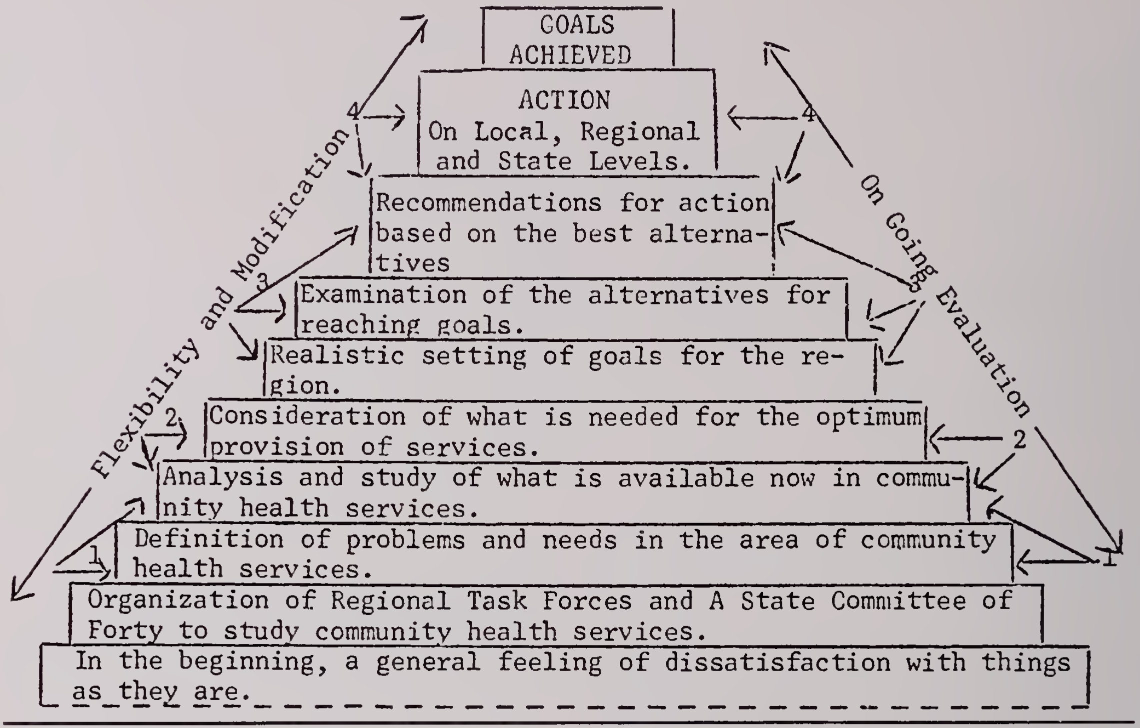
PARTICIPANTS, BY OCCUPATION, IN TASK FORCES AND COMMITTEE OF FORTY. (See also page 618.)

1. Twelve members of the Committee of Forty are the representatives of the Regional Task Forces so must be counted only once in the totals.
2. "Task Force Studies Include Physicians," *Michigan Medicine*, Vol. 65, No. 5, May, 1966, p. 346. C-40 physicians not named in article.
3. Included farm leaders.
4. Other than health and welfare.
5. A Regional Mental Health Coordinator serves both Regions I and II and is counted as a member of both Regional Task Forces; therefore, is counted only once in the grand total.

Table II shows the occupation of participants in the task forces and the statewide committee.

THE FIRST TASK force was organized in July, 1965, in the Upper Peninsula of Michigan. Gradually, the other task forces were organized in the remaining five regions of the State. It was the plan to have approximately 40 persons on each task force; the final membership ranged from 30-44. One research associate was to serve as staff for two task forces. The entire study staff (three associates serving six regions; an assistant director, who staffs the statewide committee; a sociologist, who serves as the process analyst and evaluator; three secretaries and a part-time research as-

DIAGRAM FOR ACTION IN COMMUNITY HEALTH SERVICES



GOALS ACHIEVED

ACTION On Local, Regional and State Levels.

Recommendations for action based on the best alternatives

Examination of the alternatives for reaching goals.

Realistic setting of goals for the region.

Consideration of what is needed for the optimum provision of services.

Analysis and study of what is available now in community health services.

Definition of problems and needs in the area of community health services.

Organization of Regional Task Forces and A State Committee of Forty to study community health services.

In the beginning, a general feeling of dissatisfaction with things as they are.

(STATISTICS RELATED TO TABLE II)

OCCUPATION (Generalized Category)	REGION						C/40[1]	TOTAL
	I	II	III	IV	V	VI		
Physicians - Osteopaths	1	4	2	-	4	3	4	17[2]
Bankers	1	-	-	1	1	1	2	6
Businessmen	2	3	3	4	5	4	4	24
Industrialists	1	3	2	1	3	3	2	15
Labor Leaders	1	-	1	3	-	1	1	7
Elected Officials[3]	6	9	5	8	7	6	4	43
Government Employees[4]	1	6	8	3	4	3	2	25
Educators	8	6	2	4	3	6	11	37
Church Representatives	2	2	1	1	1	-	2	8
Lawyers - Judges	3	1	-	1	1	-	-	6
Health	2	4[5]	3	2	2	3	4	17[5]
Welfare	2	1	1	1	2	1	3	11
Women's Organizations	3	-	2	-	4	1	-	10
Mass Media	1	4	1	1	3	-	2	12
Dentists	1	1	1	-	1	1	1	6
Opticians & Pediatrists	-	-	1	-	1	-	-	2
TOTAL	35	44	33	30	42	33	42[1]	246

sistant) was housed in University facilities in Ann Arbor. The Chairman of the department of community health services is director of the Study; The University of Michigan, the administrative agent. In addition, staff of the Michigan Department of Public Health and local health departments serves as consultants and resource people.

The first meeting of each task force stressed member identification of community health problems, and the fact that task forces would not be asked to rubber stamp or lobby for any predetermined program.

Each task force in collaboration with its staff consultant adopted a procedural model, diagrammed on page 618.

Task Clarification

Ultimate Goal — To assure communities throughout Michigan of the effective and efficient delivery of high quality health services which are readily available to all communities.

Task Force Goal — To study, to identify health problems, to consider solutions, to develop plans for the organization and financing of health services, and in the final analysis, to assist in their implementation.

Four Basic Questions

1. What is the present state of affairs in community health services?
2. What are the apparent weaknesses — these considered in relation to goals?
3. What steps should be taken to improve community health services (alternatives considered)?
4. What is desirable to implement the steps?

Community health services are so broad that a second model was developed to divide the Study into four manageable components. See page 618.

An Approach To The Task

Based on the definition of community health services, put components into four broad groupings:

1. Local health departments and State department of public health
2. Other official agencies (welfare, mental health, agriculture, education, water resources, etc.)
3. Voluntary agencies
4. Medical facilities and services (hospitals, nursing homes, home care, medical care facilities, etc.)

Considered beyond the purview of this Study were the quality of in-hospital services and physician-patient relationships.

For each component and each part of the component ask these three questions.

1. Who does what, how? (personnel, services, programs, administration)
2. How is it organized to perform functions?
3. How is it financed?

As each component is studied, ask how all components are interrelated and coordinated.

Rapidly the regional task force members became involved in the study and analysis of community health services in Michigan. For the first time, there was a continuing opportunity for the discussion of health issues on a regional basis. The developing interest and concern of the task force members was demonstrated by their attendance at meetings, identification of health problems, review of fact sheets sent to their homes and offices, analysis of data, and finally, in the formulation of recommendations for action—the regional reports.

A statewide Committee of Forty was created using the same method as was used in selecting task force members except that each task force had two representatives and two alternates on the statewide committee. In addition State governmental agencies, professional societies and large voluntary agencies were requested to send consultants to meet regularly with the Committee. From time to time, the members of the sponsors' Research Policy Committee attended meetings. Thus, ample opportunities were available to give professional guidance and advice to the community leaders who comprised the task forces. The Committee of Forty considered statewide health needs and problems, and within this context, reviewed and consolidated the recommendations flowing from the regional task forces.

Since this task is completed with a final critique and review in March, 1968, the Committee of

Forty and the regional task forces are exploring ways and means to implement those recommendations which they perceive to be both very important and amenable to action within a reasonable time.

PROGRESS TOWARDS implementation is just beginning to unfold. A cadre of community leaders and health professionals have participated in comprehensive studies and plans to improve regional and statewide health services. Implementation plans must depend upon the concerted effort of all professional groups as well as citizen leaders and civic groups.

The Committee of Forty report of recommendations will provide a starting point in planning for action. Copies of this report may be obtained from the Michigan Community Health Services Study, 122 South First Street, Ann Arbor, Michigan 48108, after May, 1968. □

References

1. "New Study to Survey Health Needs," *Michigan Medicine*, Vol. 64, No. 9, Sept. 1965, p. 719.
2. The provisional report of this committee, The Committee of Forty, was given final consideration at the March, 1968, meeting.
3. Project Grant CH 24-11, USPHS.
4. *Action-Planning for Community Health Services.* Report of the Community Action Studies Project, National Commission on Community Health Services, Public Affairs Press, Washington, D.C., 1967.
5. Wilson, Robert N., *Process Analysis: A Study of Community Structure and Health Action.* Public Affairs Press, Washington, D.C., 1967 (in Press).

Offer Four Day-Long Courses At 1968 MSMS Annual Session

A new feature during the two-day annual MSMS Annual Scientific Session, Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, will be four, day-long postgraduate courses in "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases," and "Difficult Decision in Digestive Diseases."

The Wednesday, September 25, courses on "Infectious Diseases" and "Pulmonary Diseases" will run simultaneously from 9:00 AM to 5:00 PM. Each course will involve approximately six hours of in depth discussion and presentation.

Martin A. Lerner, M.D., professor of medicine at Wayne State University Medical School and chief of infectious diseases at Detroit General Hospital, is moderator for the course on "Infectious Diseases." He announces that the course will be devoted to advances in virus diagnosis and therapy, including vaccines and chemotherapy, and advances in anti-bacterial usage.

"Blood Diseases" and "Difficult Decision in Digestive Diseases" will be held on Thursday, September 26.

All courses are limited to 45 persons; cost is $10 per course.

Advance registration is essential because of limitation of space.

Michigan Medicine will print further course information as it becomes available.

COMMITTEE ROSTERS AVAILABLE FROM MSMS

Physicians who are interested in obtaining copies of the MSMS committee rosters can get them from MSMS Headquarters, P.O. Box 152, East Lansing 48823.

KENT CONFERS WITH LEGISLATORS

The Kent County Medical Society has an ambitious, successful pattern of hosting their legislators each week for a luncheon session. Shown here at a typical session are, standing left to right, Senator Robert Vander Laan, Grand Rapids, 31st District; Kornelius Van Goor, M.D., Kent County Medical Society; Fred C. Brace, M.D., Kent County Medical Society; Frederick S. Gillett, M.D., Kent County Medical Society; James A. Ferguson, M.D., Kent County Medical Society; Gerald Vander Voord, M.D., Wayland, representing Allegan County Medical Society; J. Jay Post, M.D., Allendale, representing Ottawa County Medical Society. Seated, left to right, are Joseph C. Kolderman, Jr., Grand Rapids, Representative 94th District; Martin D. Buth, Comstock Park, Representative 90th District; Charles E. Farber, M.D., President, Kent County Medical Society; James S. Farnsworth, Plainwell, Representative 55th District; Melvin DeStigter, Hudsonville, Representative 95th District; John R. Wilson, M.D., President-Elect, Kent County Medical Society; Mrs. James T. Klomparens, Grand Rapids, representing Woman's Auxiliary of Kent County Medical Society.

Swanson Asks Viet Med Aid

"Right now we need to fix the wounds of the people of South Vietnam, but we also need a long range medical training program to help them take care of themselves," said Alfred Swanson, M.D., of Grand Rapids, when he appeared before the House Foreign Affairs Committee in Washington on April 11.

Doctor Swanson presented a 23-point plan relating to medical care of South Vietnamese civilians.

He called for a dramatic increase of the present AID budget, which stands at $26.1 million for fiscal 1968, to at least $500 million for the next three years.

A major point in Doctor Swanson's proposal was that American military physicians serving in South Vietnam should be made directly responsible for civilian medical care. "At present," he said, "the South Vietnamese do not have the capacity to cope with their immense medical problems so we must fill the gap."

He also spoke to the committee on the large role which medicine can play in International Affairs.

Arrangements for the testimony were made by Thomas E. Morgan, representative from Pennsylvania, chairman of the Foreign Affairs Committee, because of a request from Representative Gerald Ford, House minority leader from Grand Rapids.

MSMS President-Elect James J. Lightbody, M.D., third from left, reviews the notes from the recent MSMS conference on quackery with leaders of the three workshop-discussion groups. The leaders, left to right, were Joseph H. Shaffer, M.D.; Otto K. Engleke, M.D., and Harry A. Towsley, M.D., at right.

One of the discussion groups studies the many AMA publications against quackery, which are being used by physicians and civic groups in educational efforts. Holding the exhibit are Harry A. Towsley, M.D., left, and Phil O. Pittinger, Lansing, member of the Michigan House of Representatives.

Representatives of Many Groups Help MSMS Seek Ways to Stop Quacks

"Death, fraud, theft — these are prices Americans pay to health quacks, reports the Michigan State Medical Society."

So declared a syndicated news article that appeared across the state following the one-day MSMS-sponsored conference at the MSMS headquarters recently for attorneys, legislators, state police, members of the attorney general's staff, civic leaders and physicians.

The syndicated article explained that "in terms of death, it is estimated that more Americans lose their lives each year to quackery than to all crimes of violence put together. In terms of dollars, the take approaches $3 billion a year, with more than $100 million in Michigan alone." The extensive report on the conference was sent to all Michigan papers by Elmer E. White, executive director of the Michigan Press Association.

Maurice M. Moule, fourth from the left, was one of the several members of the State Attorney General's staff who assisted in the conference by interpreting present laws and by discussing problems in enforcement of the present fraud regulations.

THE CONFERENCE was called by MSMS to discuss possible methods of combatting health quackery in Michigan. Recommendations from the conference are being studied by The MSMS Council now.

The Lansing *State Journal* reported the event in an article with the positive headline of "Medics Open Drive Against Quacks." The article, in part, declared that MSMS "called for concentrated effort in ridding the state of so-called health quacks."

MSMS President-Elect James J. Lightbody, M.D., set the stage when he explained that the representatives of the many groups were convened so "we could put our collective experience and thinking together to determine whether we can effectively curb health faddists and fakers in Michigan."

THE PARTICIPANTS QUICKLY agreed that a legal definition of a "quack" is needed in Michigan. The group studied the new California law

Continued on Page 623

ICHIGAN
NCE

THANKS DR. HAYES

Louis F. Hayes, M.D., right, received a special citation from the Michigan State Medical Society at the recent Michigan Health Planning Conference in Detroit. Vernon V. Bass, M.D., Saginaw, left, presented a framed resolution adopted by the MSMS House of Delegates thanking Doctor Hayes for his four years of service as Vice-Speaker of the House of Delegates. The resolution lauded Doctor Hays for his "diligence and perception" in presiding over many business meetings. Doctor Hayes resigned the office when he accepted an administrative position with Michigan Blue Shield. Doctor Bass is the new Vice-Speaker.

MSMS Lists 9 PG Programs Week of May 13

The greatest number of MSMS Spring Postgraduate Programs will be during the week of May 13. During that week eight will be held in the Upper Peninsula with two teams of doctors covering the miles, and another will be in Muskegon.

The PG seminars began April 11 in Petoskey. The last will be held May 23 in Cadillac.

Many of the programs include a clinic at a local hospital in the afternoon, followed by a formal evening program.

The spring postgraduate program, being held in 19 cities around the state, is sponsored by MSMS, the Michigan Department of Health, Michigan State University, the University of Michigan, and Wayne State University.

Chairman of the Committee on Postgraduate Medical Education is Harry A. Towsley, M.D., of Ann Arbor.

Serves in Vietnam

Donald Lipsey, M.D., a general practitioner from Durand, has joined the ranks of the AMA Volunteer Physicians for Vietnam. Doctor Lipsey will return from South Vietnam at the end of May.

ANTI-SMOKING POSTERS OFFERED

A striking poster which reads "1,000 Doctors Have Quit Smoking Cigarettes (Maybe they know something you don't)" is offered by MSMS and the Michigan Council on Smoking Health to MSMS members for their offices.

Any physician who would like to receive one, or a supply of them, can get them from MSMS Headquarters, P.O. Box 152, East Lansing.

DETROIT ART SALE TO AID DPI CENTER

Bruce L. Danto, M.D., director of community psychiatry at the Detroit Psychiatric Institute, announces an art show and sale Thursday through Saturday, May 9-11, at the Northland Center Community Arts Building. The show will be sponsored by the Phi Delta Epsilon medical fraternity.

Purpose of the sale is to raise funds to establish a Suicide Prevention Center at the Detroit Psychiatric Institute. This will be the first such center in Michigan. The show will feature original oils and sculpture by local and foreign artists.

For further information on the show, contact Mrs. Milton Simmons, 18658 George Washington Road, Southfield, Mich. Tel: 356-3184.

CONTINUED: Help MSMS Seek Ways to Stop Quacks

which makes "quackery" a felony, punishable by imprisonment for up to 10 years.

All agreed that education and publicity are paramount in the battle against quackery. Recommendations were offered that educators should develop study units that would inform students about the dangers of quackery.

CONSIDERABLE INTEREST was shown in a suggestion that an agency be established to receive complaints from persons who believe they've been taken in by quacks — and that such an agency investigate and move towards court action. It was recognized that prosecution is often difficult because victims do not want to sign complaints. "Some are too embarrassed; some are dead," the newspaper accounts related.

The MSMS activities in the quackery-education field were suggested by the MSMS Committee on Public Relations. An afternoon quackery conference was part of the First Annual Conference on Michigan Health Planning held recently in Detroit. Other activities will be carried out under the direction of The MSMS Council.

MAP Capitol Trip Includes MSMS Leaders

Several Michigan physicians took part in the recent three-day Washington legislative trip sponsored by the Michigan Association of the Professions.

Attending were Gilbert B. Saltonstall, M.D., of Charlevoix, president of MAP; Bradley M. Harris, M.D., Ypsilanti, president of MSMS; James J. Lightbody, M.D., Detroit, president-elect of MSMS; Robert J. Mason, M.D., Birmingham, chairman of The MSMS Council; and Vernon V. Bass, M.D., Saginaw, MDPAC Chairman.

One of the highlights was the Congressional Breakfast April 30 at the Rayburn Building. MAP dignitaries and other invited guests met with a number of Michigan legislators for informal discussion.

Other highlights on the agenda were congressional visitations, trips to both the Nixon and McCarthy campaign headquarters, and visits with Senators Morton and Dirkson.

OFFER BOOKLET RE MSMS STAND

MSMS members interested in obtaining a copy of "Where Does MSMS Stand?" are invited to write to Hugh W. Brenneman, Executive Director, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. The chapter on "Civic and Community Affairs" is reprinted on 662-663.

DPS MEETS MAY 16

The annual lecture of the Detroit Physiological Society will be delivered by Bruce H. Stewart, M.D., of the Cleveland Clinic. His presentation will be made at 8 p.m., May 16, at the headquarters of the Wayne County Medical Society.

Did You Read Anderson Article?

Attention is called by the Publication Committee to the *Michigan Medicine* April article about "The Medical Profession and the Public: An Examination of Interrelationships."

The article is the third in a series of original papers commissioned by the MSMS Committee on Medical Socio-Economics, Dale L. Kessler, M.D., Grand Rapids, chairman. The others were "The Outlook for Group Practice-Payment, Direct Service Plans during the Next 20 Years," by Caldwell B. Esselstyn, M.D.; and "The Future of Health Insurance, Prepayment and Medicine" by Charles P. Hall, Jr. The article by Temple University Professor Hall was later judged by the National Blue Shield organization as the most scholarly article printed in any medical publication during 1967 about socio-economic issues.

The Publication Committee welcomes comments on the third article by University of Chicago Professor Oden Anderson in the April issue.

PLAN DISTRIBUTION OF MEDI-LABELS

A new study is now underway by the MSMS Committee on Highway Injury to determine what responsible lay groups would be interested in the distribution of Medi-Labels. A letter will be sent to various groups explaining the value of the project and inviting their participation in the distribution of the labels to their membership. It will be clearly emphasized that every individual receiving a sticker must take it to his physician to have the proper medical data recorded on it.

Approximately 10,000 MSMS Medi-Labels have already been distributed to physicians. Requests for Medi-Labels have come from a large Michigan lay health group and from a woman's service organization, and it is anticipated that the expected interest from other lay organizations will result in 200,000 more persons carrying the sticker attached to their driver licenses.

Kidney Disease Symposium, May 24-25

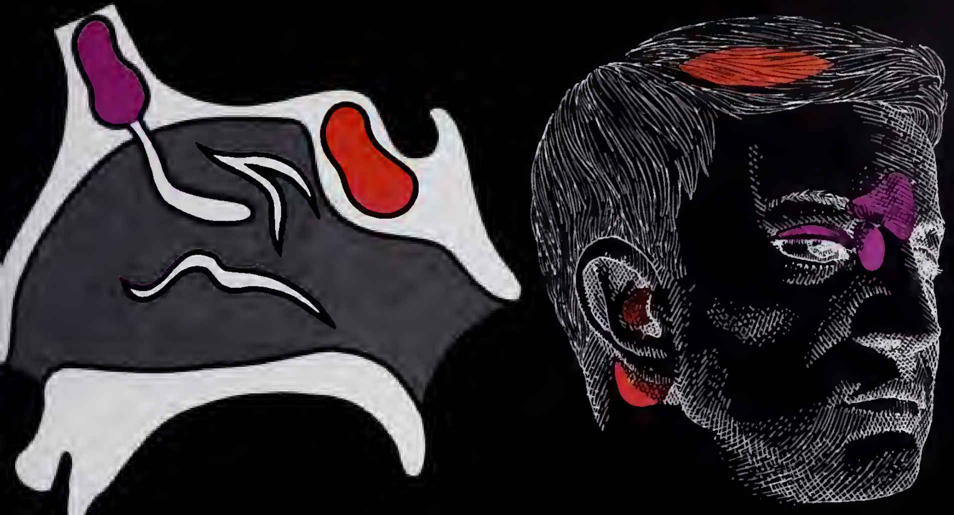
New medical knowledge about home treatment with the artificial kidney will be reported to physicians at the Seventh Annual Michigan Kidney Disease Symposium in Grand Rapids.

Sponsored by the Michigan Kidney Foundation, a United Community Services agency, the event will be Friday and Saturday, May 24 and 25 at Xavier Hall in St. Mary's Hospital.

TREATMENT OF INJURIES TOPIC FOR U-M WORKSHOP

Physicians and others interested in the subject are invited to the Third Annual Conference on the Initial Management of the Acutely Ill or Injured Patient, May 15-17, at the University of Michigan. The conference is sponsored by the Medical Center, the Extension Service, and the Highway Research Institute.

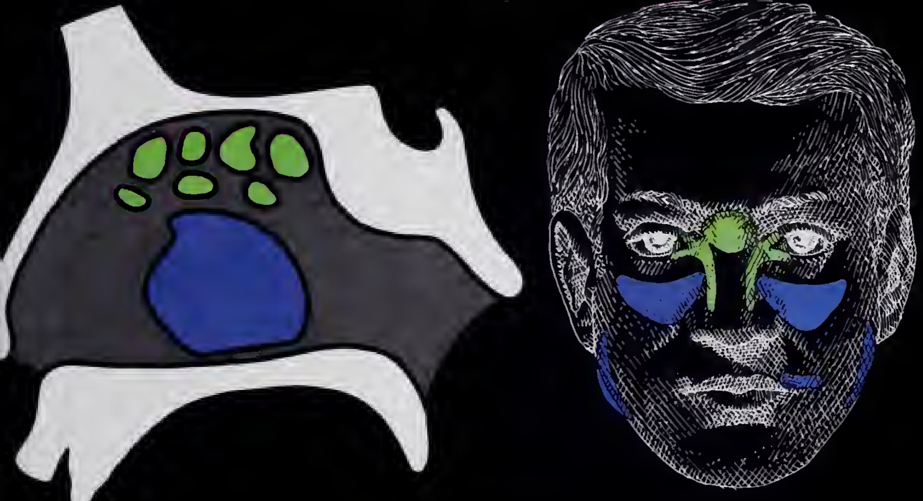
Sources of sinus headache



REGION OF SENSATION

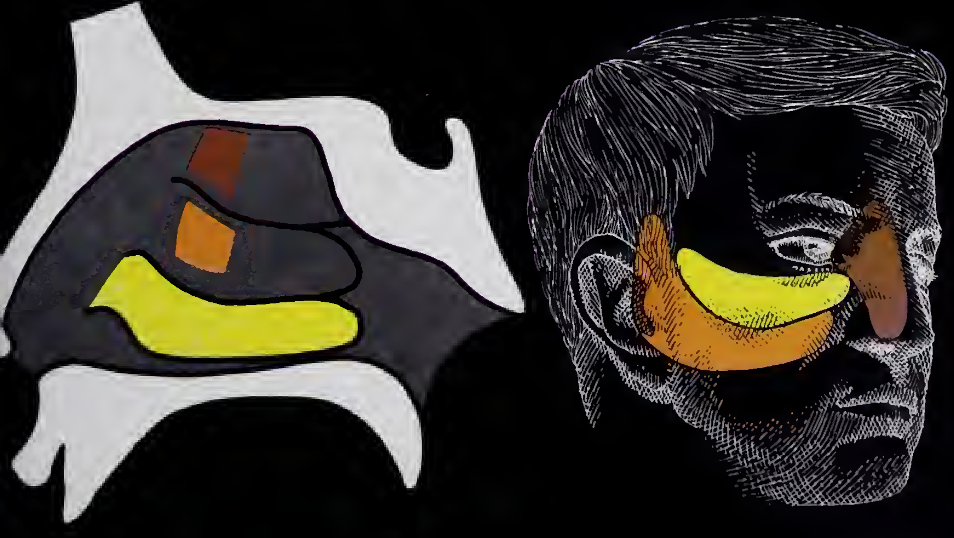
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

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Also Available on Prescription:

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AMBULANCE SERVICE
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Bedford Rescue Squad Ambulance arrived on the scene of this automobile accident just four minutes after the report of an emergency came into their office. The accident happened on a rural road, two miles from the ambulance garage. (Photo by John Boughton)

A Rural Editor Looks At Emergency Medical Service

BY JOHN BOUGHTON, EDITOR
NASHVILLE NEWS

Seven men sat around a table in the village of Nashville, Michigan a few days ago to discuss ambulance service in that small community. The purpose of the meeting was to hammer out some sort of a proposal to present to the county board of supervisors. The supervisors, in turn, are concerned with keeping their county covered with ambulance service.

The Nashville dialogue is in no way unusual. Small communities all over the state, faced with the decision of many funeral directors to no longer provide ambulance service, are attempting to solve this problem.

The Nashville group consisted of two township supervisors, two volunteer firemen, a township clerk, a newspaper editor and the local funeral director. These men were all deeply concerned with this one aspect of rural emergency medical service.

ASIDE FROM THE funeral director, who has agreed to continue to provide ambulance service until some other arrangements can be made, none of the people working on the medical problem was really professionally involved. Their sole interest was in doing what they could to solve a problem, a problem which they obviously feel is not particularly resting on the shoulders of the medical profession. They treated this as a problem of the community as a whole.

The people of Michigan's rural communities are deeply concerned with the problem of rural emergency medical service. Their handling of this one phase of rural emergency medical service, rural emergency ambulance service, is evidence that they want the utmost in this service and they are willing to do their part to see that it is provided.

The question that immediately arises is, How extreme is the problem? Are we of Michigan's rural communities really lacking in emergency medical service?

Of course, the answer is relative.

Hunger, to the American schoolboy who rushes into a well-stocked modern kitchen, starving to death, to manufacture for himself a king-sized peanut butter and jelly sandwich, is altogether different from the hunger of a child in India, who is indeed starving to death.

RURAL EMERGENCY MEDICAL care is really, in Michigan, a relative problem. Compared to other parts of the world, compared to many other states in the United States, our problems of rural health care are infinitesimal.

Yet, ideally, if one person is in need of emer-

Continued on 631

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Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

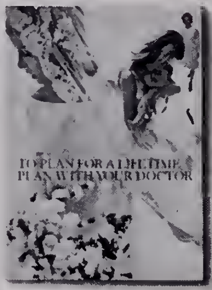
continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

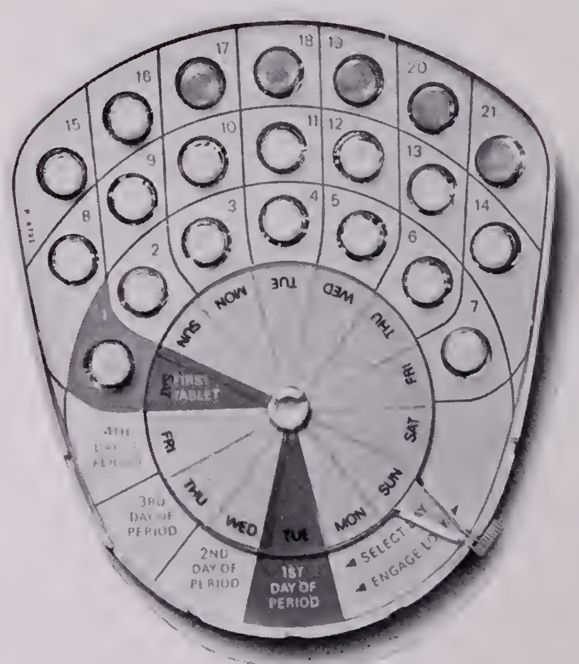
Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control



A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.



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gency health care and does not get it immediately, there is a problem in Michigan.

Perhaps compared to the emergency medical health care in the cities, at least in some respects, the rural areas are left wanting.

By the very nature of our rural communities, though, the solution to the problem may be simplified.

The smaller rural and suburban communities seem to have retained yet some of the fast-fading frontier traditions that were their heritage. This frontier tradition involves, not only doing what one can for himself, but also doing what one can for one's neighbors who may be in an emergency situation and needs immediate assistance.

This is pointed up very dramatically and often in a small rural community.

Recently, on a very cold morning, fire completely destroyed a large barn near the village of Vermontville. The members of the completely volunteer rural fire department were routed out in the early sub-zero dawn to fight the fire. Neighboring farmers showed up immediately to assist where they could. Neighboring farm housewives were in the kitchen with pots of coffee and rolls almost as soon as the fire trucks were in the yard.

There seems to be less of an air of detachment in the rural community. The "I don't want to get involved" attitude appears less prevalent.

THE ATTITUDE OF togetherness in the small rural community include the physician as the town seeks to solve emergency medical service problems.

The small town physician is known by just about everybody in the community and is a leader in the community.

The people in the urban areas are used to throwing emergencies on the shoulders of the local police. This often includes even emergency medical problems. The police department is the proper agency to handle such things.

Not so in the rural area. Here the middle man is likely to be bypassed. At a street accident in a farming or a rural community where there appears to be serious physical damage, the cry is immediately, "Get a doctor!" and more often than not a specific doctor will be named for the duty. The physician thus becomes the agency to initiate official handling of the episode.

There is little doubt that rural emergency medical service is a problem, relative though it may be. A study of rural and urban traffic fatalities in California showed that one and one-half times as many people were injured per one thousand population in traffic accidents in rural counties (under 50,000 population) as contrasted with urban counties (over 500,000 population).

The California study also showed that people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries. The higher case fatality ratio in rural areas seemed to be related to the inability to provide adequate first aid procedure and to get the person to a hospital within a reasonable period of time, according to the California study.

ROBERT E. RICE, M.D., Greenville, chairman of the MSMS Rural Medical Services Committee, reduces the problem to its least common denominator when he says that distance to the hospital and time seem to be the important factors here. Doctor Rice points out that in the case of many rural accidents, a relatively long period of time passes before the acciddent is known to those other than the ones involved and the proper help can be obtained. Often the remoteness of an accident on a farm greatly adds to this time factor.

In a case of a tractor which tipped on a child, it was almost 15 minutes before a survivor of the accident could get to the closest telephone and several more precious minutes before the tractor could be tipped up and the child removed from under it, then several minutes more to transport the patient to the nearest hospital.

Doctor Rice is of the opinion that the important factors in the problem at hand are:

1. Time

Continued on 632

The Bedford Ambulance Squad answered 1150 calls last year, many of them traffic accidents on rural roads. (Photo by John Boughton)

AMBULANCE
DODGE

2. Availability of the properly trained help for the victim.
3. Availability of proper and adequate equipment to take care of the emergency.

It probably comes as no great shock to anyone to hear that studies also show that farm workers have an unusually high accident-death rate. The Council on Rural Health of the American Medical Association says that 760,000 farm people are disabled every year in accidents on the farm. Only people who work in mines or on construction jobs have a higher accident-death rate.

These statistics would make it appear obvious that there is much to be done in the field of rural emergency medical service.

The picture is not at all bleak. Much is being done and what remains to be done can be accomplished through the cooperation of local legislative bodies, the general public, schools, farm organizations with the hospitals and physicians.

THE PECULIARITIES of the rural community, some of which have been pointed out, should make an attack of the problem less difficult than it might be. The awareness of official bodies and the general public of the problem and the willingness of the general public to help solve the problem should ease the burden of the solution.

Of course, this rural emergency medical service is but one of the facets in a giant problem presenting itself to the people of rural areas.

Michigan seems to be experiencing a population flow to the urban areas. Of course, physicians are part of this flow. This adds to the problem.

There can be little doubt that the difficulty rural areas are having in recruiting physicians makes the problem of rural emergency medical service more severe.

Lynne Holt, senior staff writer for the *Wichita* (Kansas) *Eagle and Beacon,* listed these major factors for this tendency of physicians to move to the cities, when he spoke to the 17th National Conference on Rural Health:

"1. Most physicians, particularly recent graduates, don't want to practice alone, because the responsibility is all on one man's shoulders — Vacations are few — time off is at a premium.

"2. A hospital in the community is a must with nearly all physicians.

"3. Physicians also insist on fully equipped laboratories, either in the office or in the hospital.

"4. The doctor frequently spends a year or more in general practice, then decides to specialize. This usually culminates in a move to a larger city.

"5. The physician's wife, even though she may come from a rural background, has enjoyed a new kind of life during schooling, internship, specialized training or military service. Except for 'died-in-the-wool' small-town girls, most have no desire to return to the quiet life."

While we do have this definite trend of movement out of the rural areas to the cities and suburban areas, so far as permanent housing and occupations are concerned, there is at the same time an increased mobility of these city dwellers, which makes it possible for them to flock back to the rural areas for vacations, recreation, visits, etc.

The rural highways are jammed with urbanites, "getting away from it all." The once-peaceful lakes and rivers where years ago farm boys fished with bent pins and swam dressed in nothing but goose bumps, are now being criss-crossed by high-speed power boats. The formerly tranquil snow-covered slopes of our rural hills are now being slalomed by city as well as urban skiers or snowmobiles. These people bring with them the emergency medical problems of broken legs, drownings, highway accident injuries, heart attacks and the other thousands of natural trials the flesh is heir to.

This makes the problem of rural emergency medical service something more than a purely rural problem. Rural accidents do not always happen to rural people.

THE RURAL AREAS are experiencing a change in the farming picture. Farms are being consolidated and are constantly growing larger. More land is being worked by fewer people because our engineering technology has provided the farmer with newer, bigger, faster machines. This technology also has provided the farmer, who already had a high-accident potential, with bigger, faster, more furious machines with which he could become entangled.

Add to these factors the decision of the funeral directors to no longer provide ambulance service in these rural areas Michigan faces, indeed, a need for action.

Doctor Rice, who is close to the situation, says we are pretty much in the talking stage so far as any direct action about the problem goes. It is gratifying to know that at least we are talking. There must be considerable talk and exploration before any action is taken.

While this problem of emergency medical service is but one of the many problems faced by the small rural community, it seems to be of prime interest and importance to these communities. The people of rural Michigan are giving this problem priority over some of the others.

CERTAINLY THE PROBLEM is known and is being faced by those who know it. The Ameri-

Continued on 635

...flexibility to meet new requirements

Blue Shield's new Variable Fee and Extended Benefits program meets the challenge of the changing world of medical economics. Its goal? To better meet your needs, while doing a better job for your patients.

Remember, as a Blue Shield participating physician, you're serving the best interests of your patients *and* yourself.

MICHIGAN BLUE SHIELD

A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

Weariness "without cause"

Psychic tension with depressive symptomatology?

"For weeks I've done practically nothing and I'm always tired. I wake up tired and I go to bed tired. It's really absurd."

When the patient complains of fatigue, and you can find no organic cause, you recognize that it may serve her as a means of avoiding responsibilities or facing an emotional problem. It is, in effect, a psychological retreat behind a somatic cover of continuous fatigue—one of the many depressive symptoms often associated with psychic tension.

She needs counsel and reassurance, and perhaps a tranquilizer to attenuate excessive tension and help restore the capacity to cope. As an aid to successful management, consider the value of Valium® (diazepam). As psychic tension is eased by Valium therapy, secondary depressive symptoms too may subside. The patient feels more capable, therefore more hopeful; better able to handle situations of intense stress.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions.**) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg, and 10 mg; bottles of 50, 100 and 500.

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Valium® (diazepam)

helps relieve psychic tension with associated depressive symptoms

VERMONTVILLE
F. D.

At a farm fire, the Vermontville rescue car (part of the fire department equipment) stands ready in case of a medical emergency.
(Photo by John Boughton)

can Medical Association's Council on Rural Health has offered a five-point program for improving emergency medical service in rural areas. This program, which was approved by the AMA Board of Trustees, urges that:

"1. Rural communities coordinate their efforts with adjacent towns in analyzing existing patterns of response to medical emergencies.

"2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.

"3. Rural and urban cmmunities where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care.

"4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the non-medical people most frequently called in rural emergencies — especially police, sheriffs and ambulance crews.

"5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, youth organizations and other educational channels."

According to the AMA Council on Rural Health, the long-term goal in first aid training is to have at least one member of every rural family trained in first aid procedures.

Jack R. Karel, M.D., in the Journal of the Medical Society of New Jersey, an expert in the field of disaster medical care, says that he senses a need for a change in our thinking toward this subject of emergency medical service. With the advent of the nuclear age, there seems to be a need for a new organization to cope with the tremendous number of casualties that might occur and to develop techniques and capabilities that could function under austere conditions.

He concludes that a good communications network, and a sound regionalization of control are the secrets of good disaster and emergency medical care.

Doctor Karel is of the opinion that every rescue squad and every ambulance should have a two-way radio to maintain contact with all hospitals in the area and also to maintain contact with law enforcement agencies. He says, "In time of great disaster, with excessive numbers of casualties, bedlam would otherwise ensue."

He also says that because of the importance of adequate training of ambulance attendants teaching should be standardized and intensified, and he believes this training of ambulance personnel should rest with each component medical society of the state.

MANY PHYSICIANS suggest that a community emergency medical care program can be available with an on-going daily program built around the emergency departments of all hospitals, good training of ambulance attendants in first aid, and most important, a well-coordinated and integrated communications network. All these efforts are underway in Michigan.

The most obvious answer to the problem of rural emergency medical service, of course, is prevention of rural emergencies. While this could never be accomplished 100 percent, an educational program, properly handled, should be able to greatly reduce the incidents of rural medical emergencies. Many farm and rural organizations are engaged in educational programs pointing up safety which, hopefully, will reduce the number of rural accidents.

Rural communities are making an effort to interest physicians in their areas. The Michigan State Medical Society and the Michigan Health Council, with the Health Careers Mobile, is helping to ease the situation by arousing interest in health careers.

Rural fire departments, sheriff departments and local police in many cases are stepping up their programs of first aid training, and governing bodies are trying to find ways to improve emergency procedures. Small hospitals are appraising their part in the picture. We may soon see the time when rural emergency medical service surpasses that of urban areas. □

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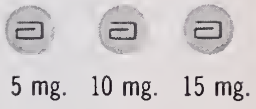

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DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
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The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444

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help you
control your
weight...

Please see Brief Summary on next page.

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Brief Summary

DESOXYN® Gradumet®
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DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

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Slides showing the incidence of arthritis in Michigan interest physicians who addressed a recent Licensed Practical Nurse Conference on Arthritis at Michigan State University. The authorities are, left to right, James J. Lightbody, M.D., medical director of the Michigan Chapter, Arthritis Foundation, and President-Elect, Michigan State Medical Society; Lanny Johnson, M.D., East Lansing orthopedic surgeon, and lecturer, Department of Anatomy, MSU College of Human Medicine, and Robert M. Daugherty, M.D., associate professor, Departments of Medicine and Physiology, MSU College of Human Medicine. The trio discussed aspects of diagnosis, treatment and nursing care of arthritis for more than 400 men and women LPN's at the Kellogg Center for Continuing Education. The Michigan Chapter of the Arthritis Foundation joined with the MSU School of Nursing and the Michigan Licensed Practical Nurses Association in sponsoring the educational event.

COMING AMA CONVENTIONS

1968: San Francisco (June 16-20)
Miami Beach (Dec 1-4)

1969: New York City (July 13-17)
Denver (Nov 30-Dec 3)

1970: Chicago (June 21-25)
Boston (Nov 29-Dec 2)

1971: Atlantic City (June 20-24)
New Orleans (Nov 28-Dec 1)

1972: San Francisco (June 18-22)
Atlanta (Nov 26-29)

1973: New York City (July 15-19)
Anaheim (Nov 25-28)

1974: Chicago (June 16-20)
Portland, Ore (Dec 1-4)

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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ-

When a milestone in life is marred by depression...

Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by depression with such symptoms as feelings of sadness, incapacity, helplessness and hopelessness.

Tofrānil often relieves symptoms of depression.

As maintenance therapy during the active phase of depression, it may help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; or in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication, or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy, the special precautions listed in the prescribing information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

Tofrānil® imipramine hydrochloride
Geigy

hypomanic and manic episodes)
ch may require dosage reduction
l/or addition of a tranquilizer or
porary discontinuation of the drug,
leptiform seizures, orthostatic
otension and substantial blood
ssure fall in hypertensive patients,
pura, transient jaundice, bone mar-
depression including agranulocy-
s, sensitization and skin rash
luding photosensitization, eosino-
lia, and mild withdrawal symptoms
sudden discontinuation after pro-
ged treatment with high doses.
casional hormonal effects (im-
ence, decreased libido, and estro-
ic effects) may be observed.
opine-like effects may be more
nounced (e.g. paralytic ileus) in
ceptible patients and in those
ng anticholinergic agents (includ-
antiparkinsonism drugs).
patient Adult Dosage: Initially,
ng. daily, increased, if necessary,

to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

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TO-5522R

COMING EVENTS

HEART SESSIONS, MAY 10-11, FEATURE HOFFMAN LECTURE

An outstanding feature of the Michigan Heart Association Scientific Session May 10 and 11 in Detroit, according to Thomas James, M.D., chairman of the program committee, will be the Second Annual Wilson-Myers Lecture by Brian F. Hoffman, M.D., chairman of the department of Pharmacology, at the College of Physicians and Surgeons at Columbia University.

Doctor Hoffman's topic will be "Electrophysiology of the Heart."

The Wilson-Myers Lecture was inaugurated to commemorate the internationally-famous work of Frank Wilson, M.D., and Gordon Myer, M.D., in the field of electrocardiography and electrophysiology.

To be held at the Rackham Building in Detroit, the program will identify various arrhythmias, their physiological implications and management. The session will offer seven credit hours by the American Academy of General Practice.

Friday morning, May 10, will be devoted to an EKG seminar for technicians, followed by the annual luncheon meeting of members.

At the end of each afternoon session, there will be time for informal discussion with speakers.

A complete program is available from the Michigan Heart Association, 13100 Puritan, Detroit 48227. □

Visschers to Lead RH Immunoglobulin Session, May 20-21

At the forthcoming meeting of the MSMS Committee on Maternal Health at the Kellogg Biological Station, Gull Lake, May 20 & 21, Robert Visscher, M.D., and Harrison Visscher, M.D., of Grand Rapids will report on the possibility of the Michigan Department of Public Health making Rh Immunoglobulin for general use throughout the state and setting up areas where plasma can be obtained. □

When eating fads of teens or tots Lead to a sudden case of "trots"

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Pectin .... (2½ grains) 162 mg.
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Usual Children's Dose: One or two teaspoonfuls three times daily.

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et's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

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A woman who is undergoing the emotional stresses of the menopause may, for the first time, need an antianxiety agent. But she may also be susceptible to drug abuse.

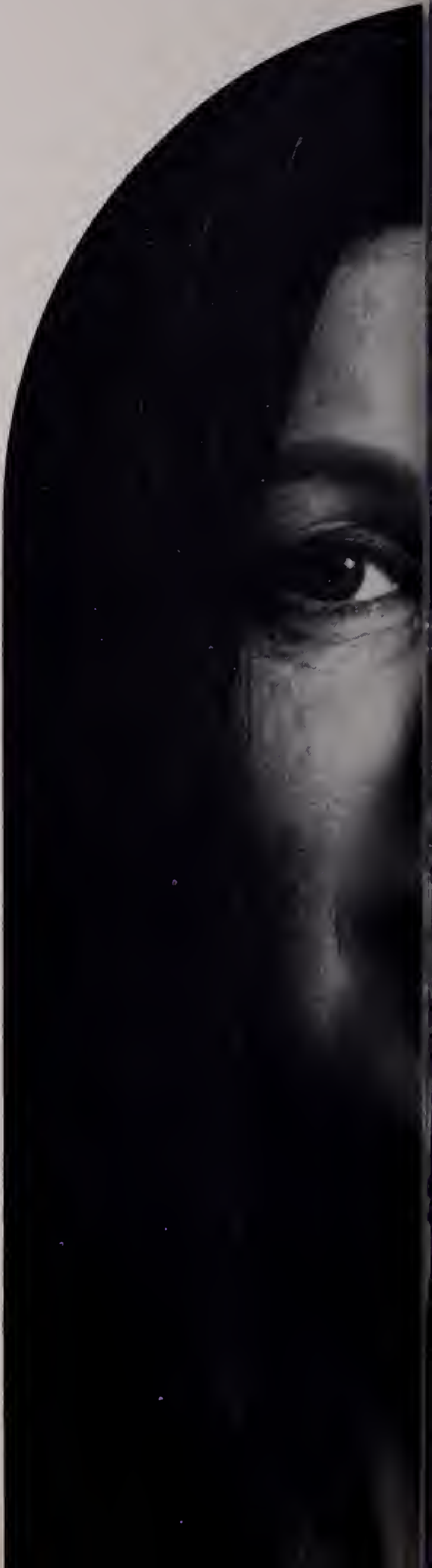
Vistaril can fulfill the need for tranquilization without creating a new need—dependency.

Vistaril calms anxiety and agitation quickly—usually begins to work in 15-30 minutes. And, in more than ten years of clinical use, after more than a billion doses to date, there have been no reported instances of dependency on hydroxyzine.

When the need for antianxiety medication is reduced or no longer exists, Vistaril dosage may be lowered or discontinued without ill effects.

Recommended starting dose, anxious menopausal patient, 50 mg. t.i.d.

With Vistaril, it is as easy to stop therapy as it is to start.



vithout
reating
new one.

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.–10 cc. vial and 50 mg./cc.–2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H.R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

burning
itching
discharge
of trichomonal vaginitis...

Flagyl® tablets/inserts

brand of
metronidazole

brings
- clinical cures
- microscopic cures
- culture cures

For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

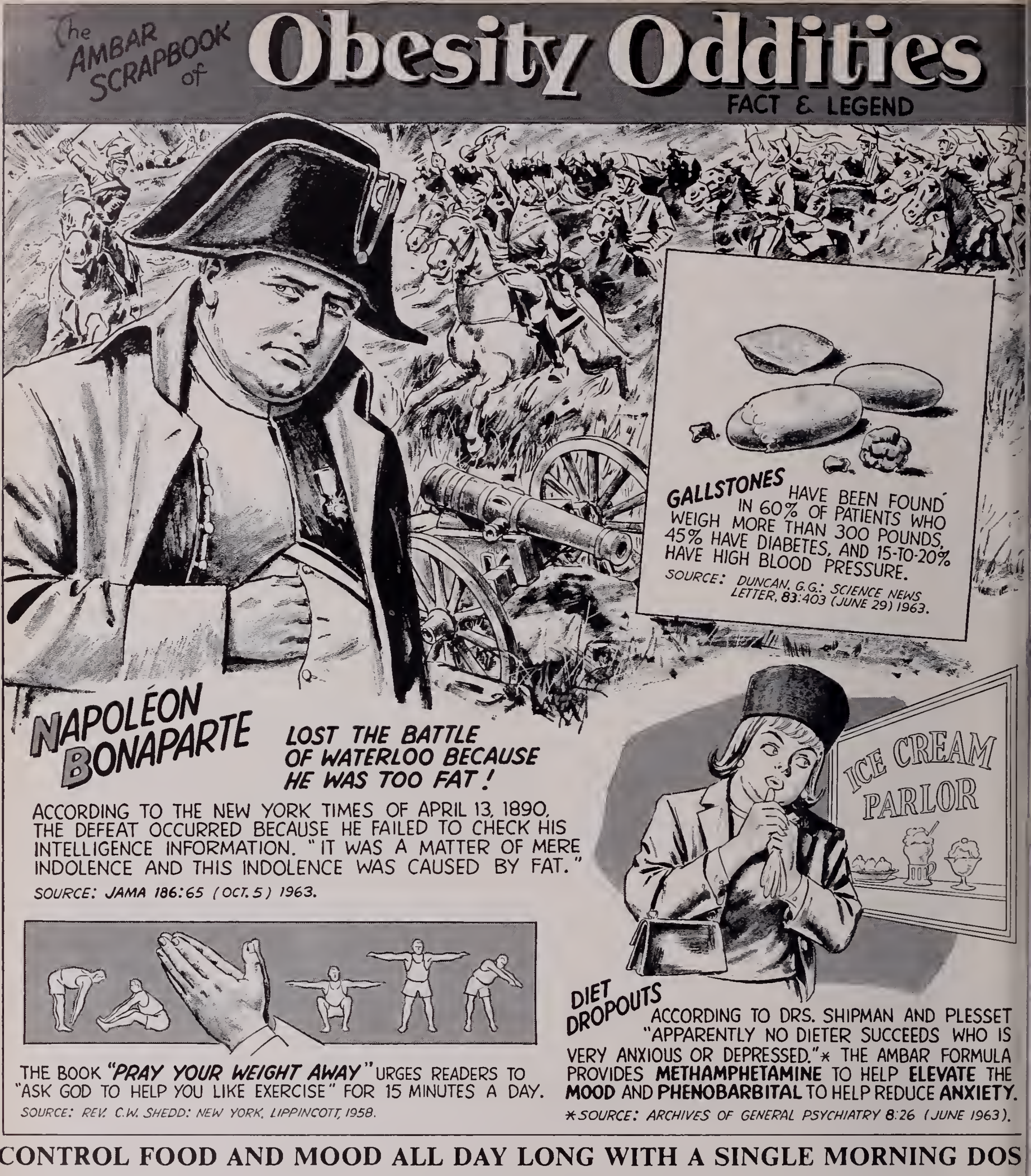
Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.

THE BOOK *"PRAY YOUR WEIGHT AWAY"* URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

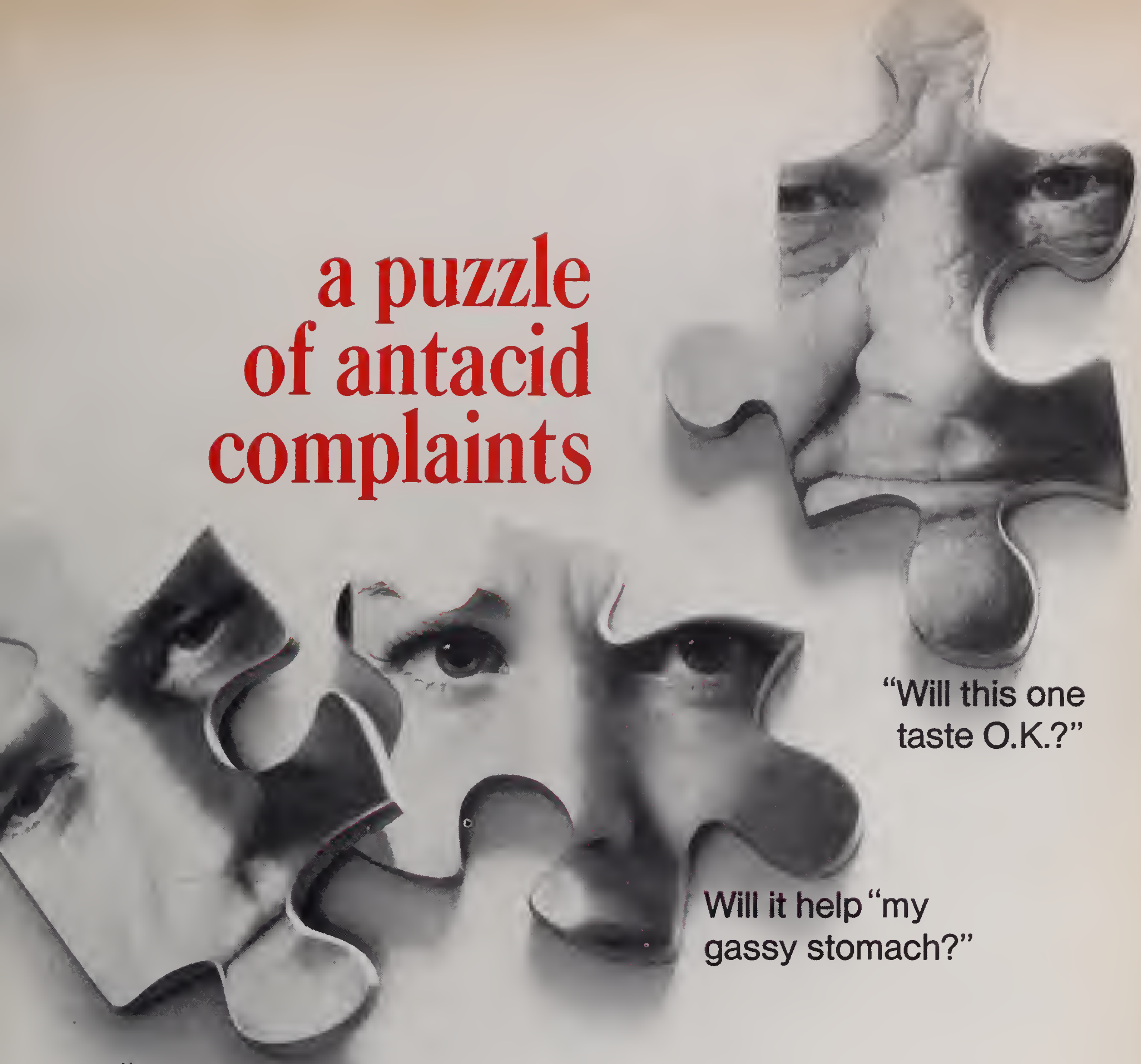
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amba suppresses appetite and helps offset emo tional reactions to dieting. **Contraindica tions:** Hypersensitivity to barbiturates c sympathomimetics; patients with advance renal or hepatic disease. **Precautions:** Administer with cau tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally note but usually infrequent at recommended dosages. Slight drow iness has been reported rarely. See package insert for furthe details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H-ROBIN

a puzzle
of antacid
complaints


"Will this one
taste O.K.?"
Will it help "my
gassy stomach?"
"Will it stop the pain?"

Mylanta®
aluminum and magnesium hydroxide *plus* simethicone

a solution
to peptic ulcer
distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

When the agitated geriatric disrupts the home...

His daughter can't please him. There is "just no living with him."

His disturbances at the table make every meal a nightmare.

His teen-age granddaughter won't invite friends home because of his outbursts.

His slovenly room and habits create more tension.

In moderate to severe anxiety...

- Mellaril helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- Mellaril often alleviates anxiety-induced somatic complaints
- Mellaril frequently helps strengthen emotional resources
- Mellaril helps the patient maintain realistic contact with environment, closer harmony with family

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

Before prescribing, see package insert for full product information.

68-11

In Obesity,
anorectic action
with fewer unwanted
side effects

CYDRIL®
(levamfetamine succinate TUTAG)

Cydril at 2 p.m.
Appetite control at 6
Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S. J. TUTAG & CO.
ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

MEDISCENE

April 30-May 1 — Woman's Auxiliary Spring Conference, MSMS Headquarters and Kellogg Center, MSU, East Lansing

May 1 — Genesee County Medical Society Cancer Day, Hurley Hospital, Flint

May 1-8 — Mental Health Week

May 4 — Thirteenth Annual All-Day Scientific Session of the Michigan Society of Anesthesiologists, Sheraton-Cadillac Hotel, Detroit

May 6-8 — Michigan United Fund, Kellogg Center, East Lansing

May 8-10 — Michigan Public Health Association, Annual Conference, Jack Tar Hotel, Lansing

May 10-11 — Michigan Heart Association Heart Days and Scientific Sessions, Rackham Center and Ford Auditorium, Detroit

May 17 — Kresge Eye Institute Clinic Day, Detroit

May 17-18 — Junior Academy of Science, Kellogg Center, East Lansing

May 18-19 — Pediatric Clinic Days

May 22 — Annual Muscle Symposium, Wayne County Medical Society, Detroit

June 5 — The Council, MSMS Headquarters, East Lansing

June 16-20 — 1968 AMA Annual Convention, San Francisco

June 21-22 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord

July 18-20 — The Council, MSMS Headquarters, East Lansing

July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

ACTIVITIES, PROJECTS

Four Doctors Serve On Board for New Data Clearinghouse

Four physicians are serving on the board for the recently-formed Michigan Health Facilities Data Clearinghouse.

MSMS spokesmen are hopeful that MHFDC will work closely with the Michigan Health Information Research Institute, being developed under MSMS guidance.

MHFDC will inventory and analyze the data generated in short-term impatient hospital facilities and the demand for this data by interested health agencies and individuals. The project is based at the Commission on Professional and Hospital Activities in Ann Arbor.

The doctors on the board include MSMS Past President Otto K. Engelke, M.D., Vergil N. Slee, M.D., and Lawrence Birch, M.D., all of Ann Arbor; and J. K. Altland, M.D., Lansing.

Funds for the Clearinghouse project are being provided by the Michigan Department of Public Health under a contract to the Commission on Professional and Hospital Activities. □

WIVES CONFER WITH LEGISLATORS

Speaking with Representative William P. Hampton, Bloomfield Hills, during the recent Woman's Auxiliary Legislative Day in Lansing, are (left to right) Mrs. Dale R. Drew and Mrs. John R. Lichtwardt, both of Bloomfield Hills.

Members of the MSMS Governmental Affairs Committee, at its last meeting, conferred with two Michigan medical leaders. Invited as guests were Albert E. Heustis, M.D., left, executive director of the Michigan Association for Regional Medical Programs; R. G. Rice, M.D., middle, acting director of the Michigan Department of Public Health. Listening intently to their comments is Paul T. Lahti, M.D., right, Royal Oak, chairman of the MSMS Committee.

Krevsky Serving In AMA Viet Plan

Seymour Krevsky, M.D., Detroit, is in South Viet Nam for two months, serving the civilian population with the American Medical Association Volunteer Physicians for Viet Nam.

He is a pediatrician in private practice and director of nurseries, Detroit Memorial Hospital. Practicing in Philadelphia 1960-64, he was instructor of pediatrics at the University of Pennsylvania Graduate Hospital and was affiliated with Presbyterian Hospital.

Doctor Krevsky attended Lehigh University, Bethlehem, Pa., and Yeshiva University, New York City, and received his medical degree from Jefferson Medical College, Philadelphia, Pa.

AMA Volunteer Physicians for Viet Nam is administered by the American Medical Association, under contract, for the United States Agency for International Development. It is a program designed to use the volunteer services of U.S. physicians to assist in meeting the health needs of the Vietnamese civilian population. □

WHEN YOU MOVE—LET US KNOW!
WE WANT YOU TO BE SURE TO GET
THE NEXT ISSUE OF THE
MICHIGAN MEDICINE

Feldkamp Installed; Haddock, Danforth Elected by G.P.s

Lee Feldkamp, M.D., Plymouth, was installed as president, and Douglas A. Haddock, Jr., M.D., Kalamazoo, selected as president-elect at the recent 22nd annual convention of the Michigan Academy of General Practice.

The installation was impressive with J. L. Leach, M.D., Flint, as the outgoing president. Special guests at the annual banquet at the Sheraton-Cadillac Hotel Grand Ballroom included Frank Bicknell, M.D., President, W.C.M.S., and James J. Lightbody, M.D., President-Elect of MSMS; Assistant Dean Morton Levitt, Ph.D., of Wayne State University; Dean Andrew Hunt, Jr., M.D., Michigan State University School of Human Medicine and Mrs. William N. Hubbard, Jr., M.D., representing her husband, Dean Hubbard, University of Michigan Medical School, who was out of the state on pressing University affairs.

Other officers elected were Secretary, E. C. Long, M.D., Detroit; Treasurer, Robert Oakes, M.D., Harbor Beach; Directors, H. R. Allott, M.D., Sault Ste. Marie; W. D. Peterson, M.D., Traverse City; T. J. Rupp, M.D., Grand Rapids; H. Weisheit, M.D., Sturgis; H. A. Habenicht, M.D., Jackson; Lewis Simoni, M.D., Flint; T. F. Lange, M.D., Lansing; C. Ludwig, M.D., Port Huron; R. Vitu, M.D., Saginaw; Joseph Schirle, M.D., Pontiac; Leon Rottenberg, M.D., Detroit; and L. R. Zako, M.D., Allen Park.

The delegates elected James J. Danforth, M.D., Detroit, as Speaker and James F. Dooley, M.D., Flint, Vice-Speaker. Chosen as delegate to the A.A.G.P. was Clark W. Royer, M.D., Battle Creek; Alternate Delegate, J. L. Leach, M.D., Flint.

The convention program and banquet menu were printed in green and gold to commemorate the WSU School of Medicine Centennial.

"The clinic, in spite of a state-wide storm that rendered driving expressway hazardous and hampered operations at Metropolitan Airport, our twenty-four guest speakers from all sections of the United States, arrived and delivered their papers on schedule. Although the storm reduced our usual outstate representation, this was offset by more physicians than ever attending from the greater Detroit area," reported F. P. Rhoades, M.D., Detroit, director, M.A.G.P. Scientific Assembly.

Lee Feldkamp, M.D., right, receives congratulations as the new president of the Michigan Academy of General Practice from J. L. Leach, M.D., who completed his year. At left is Douglas A. Haddock, Jr., M.D., who will serve as president during 1968-69.

Doctor Rhoades reported that "in addition to the formal program, there were 32 scientific exhibits present selected to complement each of the papers presented as well as amplifying the five wet clinics. All wet clinics were well attended with over 115 of our members present, and the five clinics were provided with appropriate patients suffering from the disease or disorder being covered. Local voluntary health agencies cooperated in supplying the patients. These included the Arthritis and Rheumatism Foundation, the Michigan Allergy Society, and the Kresge Eye Institute: others supporting the program were Michigan Epilepsy Center, and the Michigan Heart Association." ☐

COLE HONORED

Wyman C. C. Cole, Jr., M.D., of Detroit, past chairman of the Board of Directors of MDPAC, receives a plaque commemorating his outstanding work with the organization from Vernon V. Bass, M.D., of Saginaw, present chairman of the Board, at a recent MDPAC meeting in Detroit.

Participating in a recent MAP Formula TV program were, left to right, host, Hugh Brenneman, MSMS Executive Director; George W. Slagle, M.D., Battle Creek; Edward R. Annis, M.D., Miami, and Frederick C. Swartz, M.D., Lansing. "Formula for New Medical Care" was the topic. Doctor Slagle is Chairman of the AMA Council on Medical Service, and a Past President of MSMS. Doctor Annis, a graduate from the University of Detroit, is a Past President of the AMA and the World Medical Association. Doctor Swartz, who helped originate the Rehabilitation Center at Sparrow Hospital in Lansing, has served several years as Chairman of the AMA Committee on Aging.

VIET MEDAL OF HONOR AWARDED TO SWANSON

For his assistance to the South Vietnamese medical community, Alfred B. Swanson, M.D., of Grand Rapids, has been awarded the South Vietnamese Medal of Honor. Since 1962, Doctor Swanson has made four volunteer trips to Southeast Asia.

The citation noted that he "has successfully operated on military patients treated in Cong Hoa Military Hospital and provided theoretical and practical training to Vietnamese surgeons, with fully satisfactory results."

Doctor Swanson is chief of the orthopedic department at Blodgett Memorial Hospital and chief of staff at Mary Free Bed Hospital. ☐

HELP NEW PARENTS IN OAKLAND COUNTY

The Oakland County Medical Society will cooperate with the Oakland County Health Department and various adult education departments to offer a series of eight classes for expectant parents.

The classes, which are taught by public health nurses, make use of films and other audio-visual aids and include a hospital tour. ☐

YOU
AREN'T
A BANKER
DOCTOR . . .

Too much of your time is taken up with "banking matters" — primarily the follow-up on patient's unpaid bills for your services. If your patient belonged to the American Health Credit Plan, he could arrange for A.H.C.P. to pay his bills — with something we call "instant money." You get paid instantly, eliminating unnecessary office work. Through the A.H.C.P. plan you have more time — time to be a doctor, instead of a banker.

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MICHIGAN'S ONLY
MEDICAL CREDIT CARD

State Medical Auxiliary Promotes Home-Centered Health Care Program

BY MRS. E. C. GALSTERER, CHAIRMAN
STATE WOMAN'S AUXILIARY
HOME-CENTERED CARE

The Woman's Auxiliary to the Michigan State Medical Society has joined this year in a nationally-supported, medically-oriented community service program, dedicated to providing home health care in special cases in order to relieve pressure on regular medical and hospital facilities.

Especially encouraged are: (1) Homemaker Service, (2) Portable Meals, and (3) Voluntary Friendly Visitors.

While the first of these is the most comprehensive program, there are many cases in which a more simple service, such as regular personal contacts or assurance of balanced meals, would be adequate. All three programs should be of interest to the medical profession and are appropriate fields of interest for doctors' wives. The wives can through these projects provide emergency assistance, adequate nutrition and stimulation of interests to the chronically ill, disabled, handicapped, the lonely and homebound elderly, and those who need temporary care due to special problems in the home. They make home care possible for many patients who might otherwise require space in hospitals or rest homes.

However, these services should be considered not as a substitute for hospital or institutional care but as part of a total medical care plan.

HOMEMAKER SERVICE, for example, can serve not only to provide home help for a patient who could go home from the hospital sooner, if being at home did not involve too many household duties, but also can help the home and family to function normally when the mother is suddenly hospitalized, so that the wage earner need not stay at home or the children be boarded out. Clients usually pay for this service insofar as they are able. Moreover, there is customarily a time limit involved in such service which is intended to take care of the emergency without providing long-term, high-priced maid service at the expense of civic-minded women.

Auxiliaries have been encouraged to act as catalysts in promoting community interest in such projects, providing necessary training courses for special services, and recruiting volunteers. Some have offered the services of their own members. Most projects, however, are carried out in cooperation with an existing social service agency. Several Michigan County Auxiliaries have shown interest in this program and are investigating the extent of need and possibility of continued support in their communities.

ONE GROUP WHICH recently inaugurated such a service is the Bay-Arenac-Iosco Counties Auxiliary, whose "Mobile Meals" program began operation on April 1st, after a full year of study and inquiry under the leadership of Mrs. Nicholas Csonka. The present coordinator is Mrs. Kent Alcorn.

With the participation of Bay City's Mercy Hospital in planning, preparing and packaging the meals, the cooperation of the Nursing Bureau in providing telephone answering service, the service of the Visiting Nurses and Public Health Department in screening applicants, and the guidance of the Child and Family Service in instructing drivers, the Auxiliary volunteers are putting into effect a three-month pilot project for up to ten clients. Five days a week, they provide a hot noon meal, a cold supper, and supplies for the next day's breakfast, at a price of $2.00 a day—a charge barely above cost.

Financial backing to start this project comes from a share of the proceeds of the Auxiliary's annual Christmas card sale. At present, all clients pay for their own meals. Auxiliary leaders, however, anticipate expansion of this demonstration project into a community program and hope for sufficient funds to make possible lower meal prices adapted to the economic status of those who are most in need of such service. □

Hairy sites where creams and ointments do not spread or penetrate readily.

Exposed areas where cosmetic considerations are important.

An invisible topical

for many dermatologic problems

Moist or intertriginous-areas where drying action is desirable.

See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication — or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.

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and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025% – 5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01% – 15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025% – 15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream – 5, 15 and 60 Gm. tubes.

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MSMS Presents New 'Flag Awards'

Photos from 1968 Awards Luncheon At Conference on Health Planning

Carl B. Beeman, M.D., right, of Grand Rapids, received a Michigan State Medical Society Flag Award. Unable to attend the recent Michigan Health Planning Conference in Detroit, Doctor Beeman received his award in Grand Rapids. He was cited for "his distinguished leadership as president of the Michigan Heart Association. C. Allen Payne, M.D., Grand Rapids, past president of the medical society, presents the award.

John J. Hanlon, M.D., right, of Detroit, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of Michigan Public Health Association. B. M. Harris, M.D., society president, presents the award.

George D. Maniaci, M.D., right, of Gladstone, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Association for Retarded Children." The award was presented by MSMS President B. M. Harris, M.D.

HEALTH
PLANNING
CONFE CE

Donald R. Hagge, M.D., left, of Livonia, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Archaeology Society." B. M. Harris, M.D., Ypsilanti, society president, presents the award.

HIGAN
ALTH
NNING
CE

William N. Hubbard, M.D., right, of Ann Arbor, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Association for Regional Medical Programs." MSMS President B. M. Harris, M.D., offers congratulations.

HEALTH
PLANNING
CONFERE

G. Frederick Moench, M.D., left, Midland, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Society for Better Hearing and Speech." The citation was presented by MSMS President B. M. Harris, M.D.

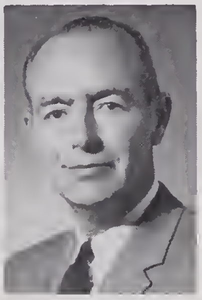
Photos of More Distinguished Leaders

John B. Rowe, M.D., right, Flint, received a Michigan State Medical Society Flag Award at the recent Michigan Health Planning Conference in Detroit. He was cited for "his distinguished leadership as president of the Michigan Diabetes Association." The award was presented by MSMS President B. M. Harris, M.D.

PLANNING
CONFERE

Harry A. Towsley, M.D., left, of Ann Arbor, received a Michigan State Medical Society Flag Award from B. M. Harris, M.D., Michigan State Medical Society president, at the recent Michigan Health Planning Conference in Detroit. Doctor Towsley was cited for "his distinguished leadership as president of the Michigan Health Council, and also the Michigan United Fund."

G. B. Saltonstall, M.D., of Charlevoix, was cited for "his distinguished leadership as president of the Michigan Association of the Professions."


SALTONSTALL

JEFFRIES

Benjamin Jeffries, M.D., of Detroit, was cited for "his distinguished leadership as president of the Michigan Epilepsy Center and Association." Doctor Saltonstall and Doctor Jeffries were unable to attend the Conference to receive their awards.

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What Is Current Thrust of MSMS In Civic and Community Affairs?

Civic and community affairs have always been — and certainly are today — a concern of MSMS.

Where does MSMS stand regarding civic and community affairs? That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Thirteen different questions are discussed in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November issue of *Michigan Medicine*, on pages 1439 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter VIII in the booklet.

CIVIC AND COMMUNITY AFFAIRS

Discussion

Relationship Between Patient Environment and Physician Concern

The relationship between some non-medical issues and the practice of medicine has never been clarified in MSMS literature, but a very real connection exists. Involvement in issues with which the public has a vital stake enables a physician to become more aware of the requirements of society.

For example, how many physicians visit neighboring industrial plans, tour neighborhoods to see living conditions, acquaint themselves with sanitation problems — or even familiarize themselves with what agencies provide what services in the communities in which their patients live?

How can the physician demonstrate a personal concern for his patient, assist him in avoiding illness and accident, if he has no familiarity with the working and living conditions of the patient and his family? Has this lack, coupled with improved transportation (causing a decline in house calls), an answering service, and a central medical office building caused the physician to become isolated from the problems of his patient and given him the image of an efficient impersonal individual?

Human Resources Council

Physicians can get involved in a myriad of organizations, offer guidance through them towards improving the health of the public, and thus the profession can identify itself with the problems of individuals. One of the ways this can be done is through participation in the work of the Human Resources Council, which sponsored the Michigan Assembly,* a meeting called in cooperation with the University of Michigan to study the future of the environment and employment of the people of Michigan.

Highway Accident Prevention
Air-Water-Land Pollution
Population Control

Others open for participation are these organizations involved in highway accident prevention; air, water, and land pollution; conservation clubs, PTA, chambers of commerce, conferences on population control,* etc. These tend to be one step removed from the sociological medicine where health is the pervasive subject.

*MSMS participated

Contact Via MAP and TV with Other Professions

MSMS has been particularly effective in these fields, in part because of its participation in MAP and the "Formula" television program, which has supplied a broad base for contact with community affairs.

Political Candidate Support

Particular attention is deserved by MDPAC, which has not received the support in Michigan that similar organizations have in other states. In many states PAC dues have been collected concurrently with state society dues. There is need for continued study of this. But regardless of financing, the work of this organization, which has been well begun, needs greater MD interest if it is to continue to be effective in the support of political candidates who reflect this profession's policies.

Urbanization Civil Rights

Two other areas where physicians might make contributions to civic and community affairs are the advices they can give in urbanization and civil rights.

Community Health Week

Community Health Week, of course, offers amazing opportunity for involvement in community activity. However, this activity tends to fall in the communications and public relations or socio-medical fields of interest rather than in the "other-than-health" thrust of this section.

The above is not said to deprecate or ignore the fine work of many physicians in serving in local school boards, city councils, village and township boards, etc. Quite the contrary, this type of service is of the essence.

Questions

A. Should a study be made of the role MSMS should play in resolving the Negro problem? **Negro Problem**

B. Should a study be made of the probable effect the civil rights movement will have upon medical practice in Michigan? **Civil Rights**

C. Should the MSMS finance any part of MDPAC activity? **MDPAC**

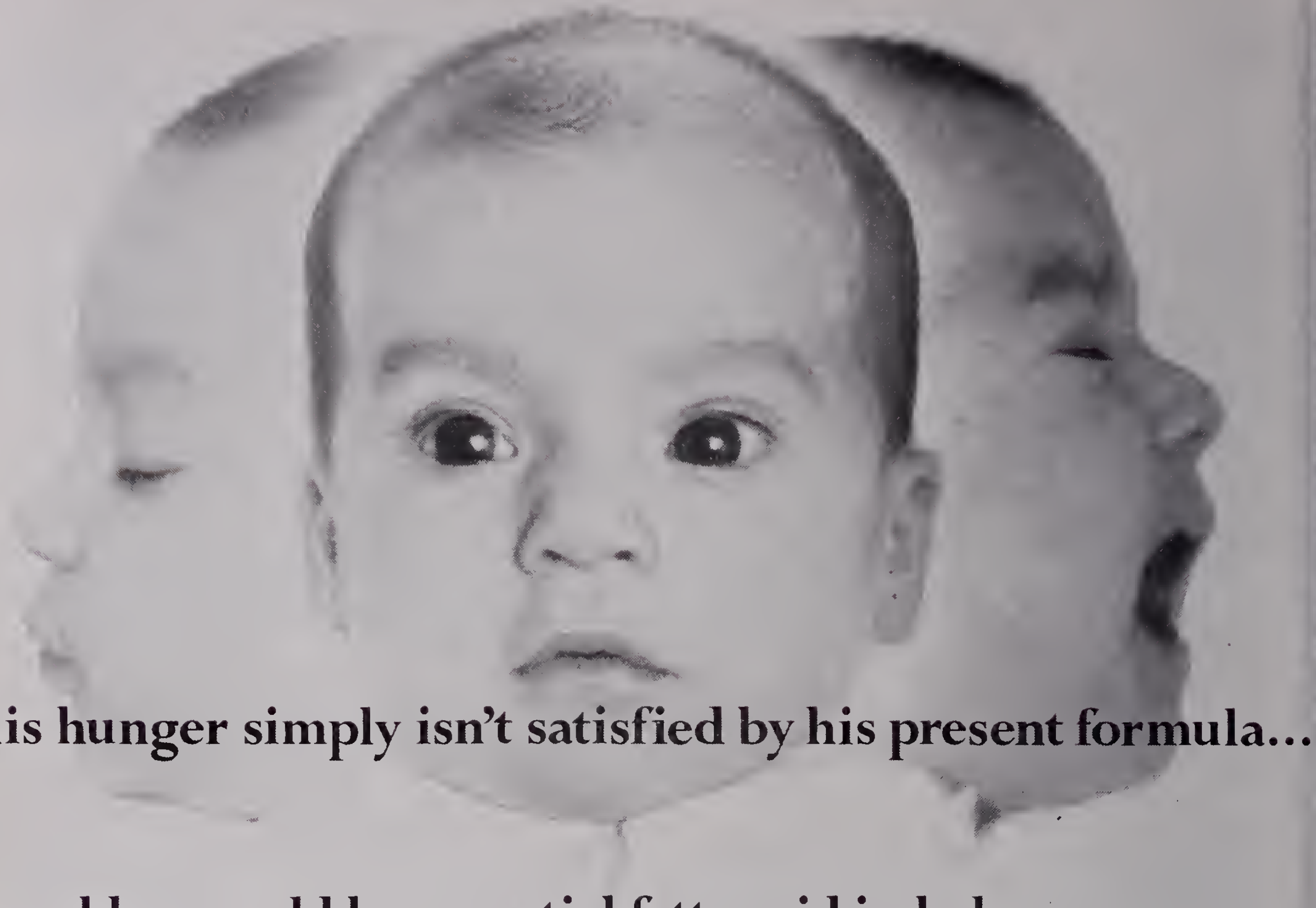
D. Should the MSMS participate in Human Resources activity **Human Resources**
   1. As a leader?
   2. As an active participant?
   3. Not participate?

E. What part should MSMS play in population control? **Population Control**
   1. Assist it?
   2. Ignore it?
   3. Oppose it?

F. Should the MSMS participate actively in the national, state, and local chambers of commerce? **Chamber of Commerce**

G. Should the MSMS establish any formal liaison with the Michigan Congress of Parents and Teachers or the Michigan Association of Child Study Clubs, and other parent education groups? **PTA, etc.**

H. Should MSMS be an active participant in anti air, water and land pollution campaigns? **Air-Water-Land Pollution**



If his hunger simply isn't satisfied by his present formula...

the problem could be essential fatty acid imbalance

Excessive appetite, inordinate crying, poor weight gain and skin rashes can be caused by an infant formula that does not have fatty acid balance.[1-5] Linoleic acid is a required nutrient which is converted, in part, to metabolically-active arachidonic acid. Preliminary studies have shown that linolenic acid, if present in sufficient quantity, can adversely affect this conversion. Optimil has only trace amounts of linolenic acid.

Fat analyses of Optimil and two leading modified-milk formulas*

Fatty acids	Optimil % of fat	Prod. #2 % of fat	Prod. #3 % of fat
Saturated	**40.4**	**44.2**	**39.0**
Caprylic	3.3	1.6	2.2
Capric	2.2	1.1	1.5
Lauric	16.0	10.1	11.7
Myristic	6.3	5.1	5.5
Palmitic	10.2	16.2	14.0
Stearic	2.3	9.0	4.5
Unsaturated	**59.6**	**55.8**	**61.0**
Oleic	40.7	33.0	24.7
Linoleic	18.9	19.5	34.6
Linolenic	trace	2.3	1.7

* Mean of three lots tested

ptimil, an optimum-nutrition infant formula, helps reduce problems

feeding

v Optimil from Carnation tains more than enough linoleic l and only a trace of linolenic. is Optimil-fed infants maintain quate tissue levels of chidonic acid. This is reflected the high caloric efficiency Optimil, and helps to satisfy ger and promote efficient ght gain and a clear complexion akes an infant contented.[6-8]

ecommend Optimil

optimum contentment, imum digestibility and optimum wth, recommend Optimil, the imum-nutrition infant formula. mes in the new full 16-fluid ce can for maximum venience in formula preparation. ilable only at drug stores.

in digestibility

Of all the fatty acids commonly found in infant formulas, stearic acid is the least digestible.[9] Optimil contains a comparatively low level of stearic acid and a relatively high level of oleic acid, which has been shown to aid in the absorption of stearic acid. Optimil also has a high ratio of unsaturated fat to saturated fat which further enhances the formula's digestibility.

1. Hansen, A. E., et al: Pediatrics 31:171, 1963. 2. Holman, R. T.: Fed Proc. 23:1062, 1964. 3. Holman, R. T., et al.: Amer. J. Clin. Nutrition 14:70, 1964. 4. Hepner, R., et al.: Pediatrics 33:94, 1964. 5. Pikaar, N.A., and Fernandes, J.: Amer. J. Clin. Nutrition 19:194, 1966. 6. Hepner, R.: Current Therapeut. Research 9:140 (Suppl. 35) 1967. 7. Hart, L. M.: Ibid., p. 179. 8. Nichols, M. M.: Ibid., p. 184. 9. Young, R. J. and Garrett, R. L.: J. Nutrition 81:321, 1963.

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Optimil, an optimum nutrition infant formula, from Carnation

E. Stewart Taylor, M.D., right, chairman of the department of Obstetrics-Gynecology at the University of Colorado Medical Center, was one of the featured speakers at the MSMS Maternal Welfare Conference in Flint recently. His daughter, who lives in Ann Arbor, and William W. Jack, M.D., left, of Grand Rapids, immediate past chairman of the Maternal Welfare Committee, confer with Doctor Taylor.

Rh Immunoglobulin, Abortion Discussed At Flint Conclave

BY PETER HOHEISEL
OF THE MSMS STAFF

Early in the program, the challenge faced by the 1968 Maternal and Perinatal Welfare Conference held in Flint recently was outlined by William W. Jack, M.D., immediate past chairman of the conference.

"Here in Michigan we need to improve our perinatal mortality rate," Doctor Jack said. "In cooperation with the Maternal Health Committee, the State Health Department has released statistics recently showing that while the national mortality rate per thousand live births is 23.4, Michigan statistics have ranged, in the period 1964-66, from 27.4 to 32.7 depending on the size of the hospital participating in the study."

Topics dealing with this subject at the conference ranged from "Neonatal Environmental Control" to "Infertility." One-hundred-seventy-five physicians, 22 osteopaths, and 146 others from medical and social work groups, making a total of 343, participated in the conference.

Many participants voiced appreciation for the work of the 1968 Maternal and Perinatal Welfare Conference Committee, chaired by Jack W. Thompson, M.D., of Flint, for preparing an educational program on a wide spectrum of subjects of interest to physicians, medical personnel, and the public.

A TALK WHICH attracted national as well as local news attention was "New Abortion Laws," by E. Stewart Taylor, M.D., chairman of the department of obstetrics-gynecology at the University of Colorado Medical Center.

Doctor Taylor gave a report on how the new abortion law in Colorado has been working during a nine month period, May 1, 1967, to February 1, 1968. Out of a possible 52 hospitals, accredited by the Joint Commission, 23 have established boards to handle theraupetic abortions in Colorado, he said.

In the nine month period, 224 abortions, a ninefold increase over previous years, have been performed. 145 of these women were Colorado residents; the rest were out of state, Doctor Taylor said.

Single women had 51% of the abortions; married women, 36%; divorced, 10%; and widowed, 3%.

PSYCHIATRIC REASONS LED the list of indications for abortion with 67%. Most of the psychiatric conditions, Doctor Taylor said, were related to "reactive and situational depression." Some hospital boards require that the condition be present before the pregnancy. Fetal problems, rape, and medical difficulties for the women, in that order, accounted for the rest. Maternal rubella was the main culprit in fetal indications. Forty of the 224 abortions resulted in further complications. This high incidence, according to Doctor Taylor, was based on the "red tape" involved in getting the abortion approved.

With regard to the socio-economic status of the women receiving the abortions, over 50% of them were in a family income bracket of less than $5500 a year. "This shows," said the Colorado physician, "that therapeutic abortion isn't available only to those who can afford it."

Doctor Taylor remarked that the new abortion law was working out well and that, contrary to what some of the critics had predicted, Colorado was not becoming the "abortion mecca of the country."

He preferred to describe the law as "permis-

Continued on 671

vol. 3, no. 2

DORSEY Season

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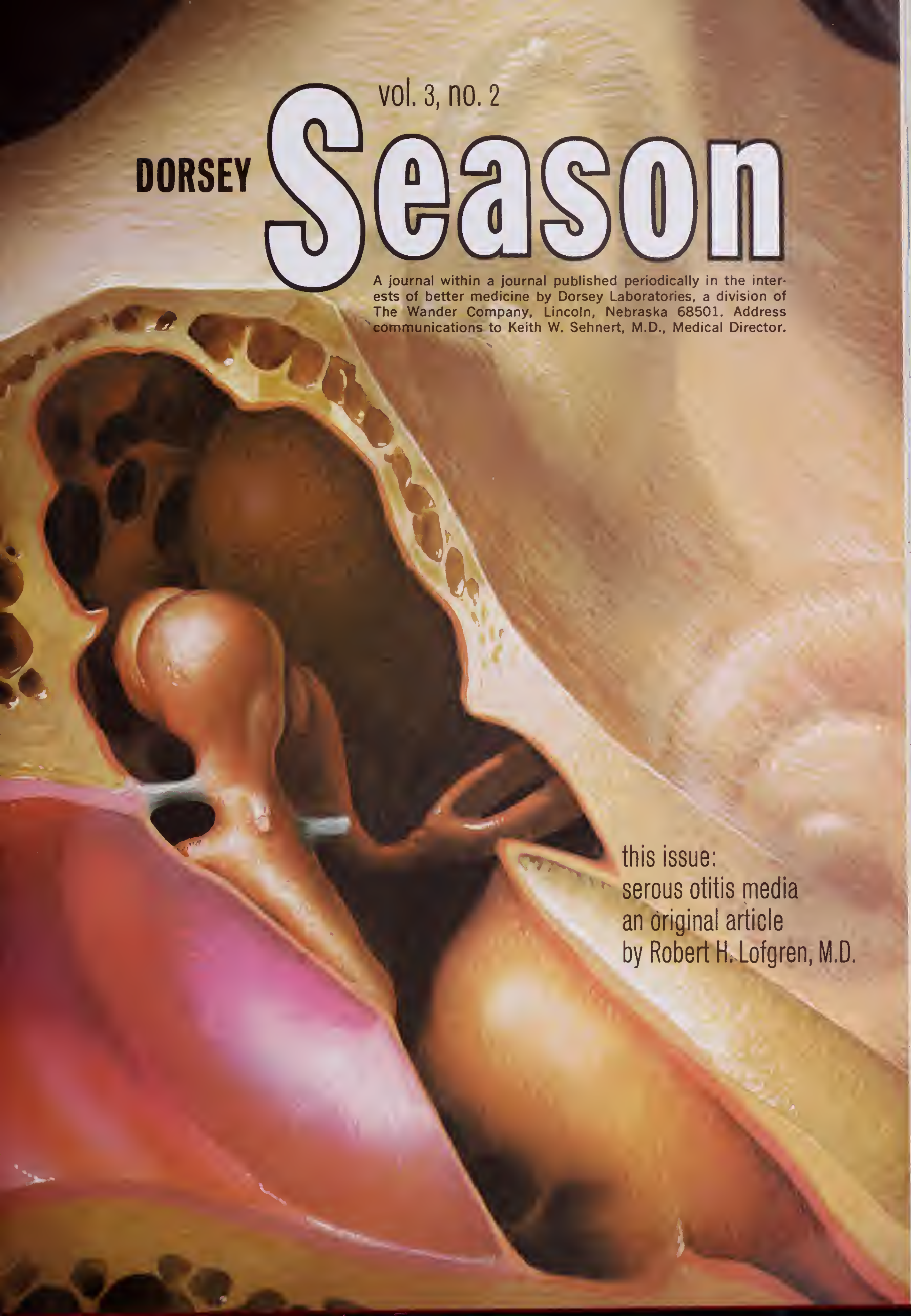
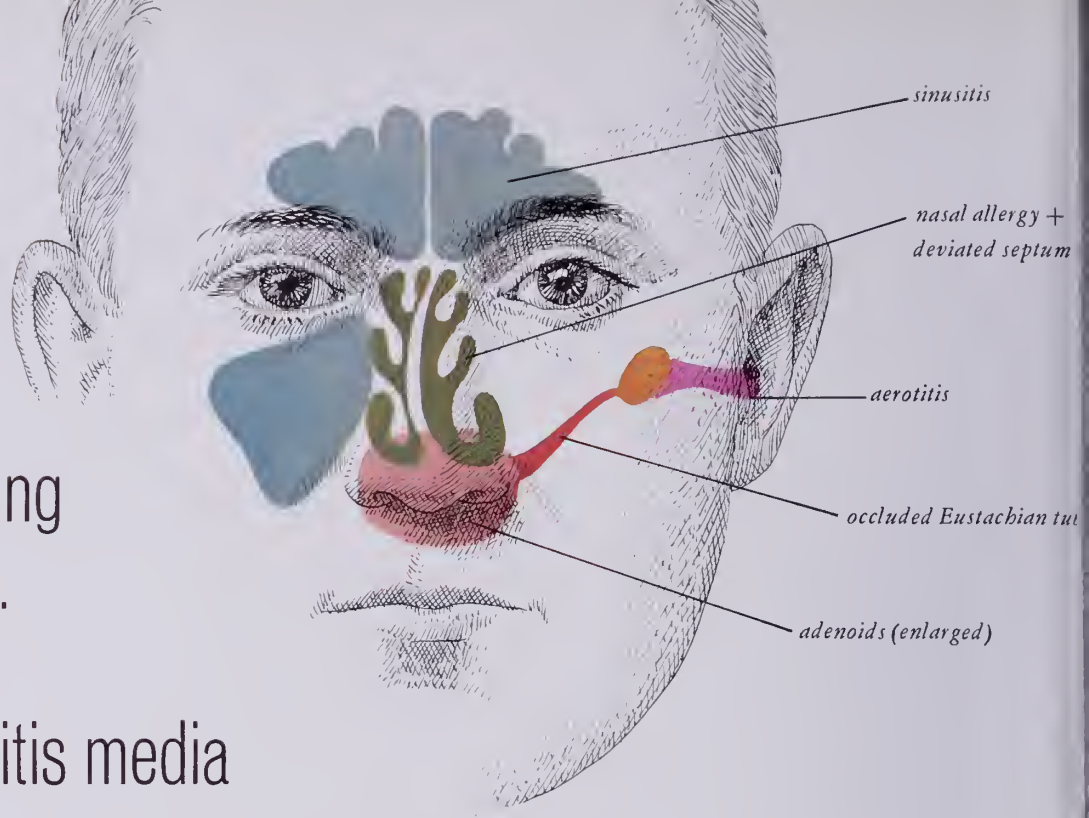


this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

the first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection n the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or denoiditis. When the infection heals there may be carring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent nd to provide drainage from the middle ear. Often his can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they hould be removed. Sinusitis should be treated with ral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

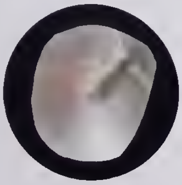
f the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if he fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood est. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between he ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure nflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

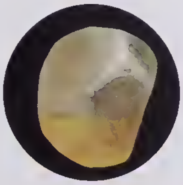
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

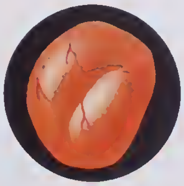
Otoscopic Views



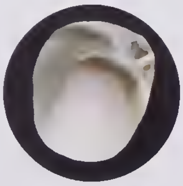
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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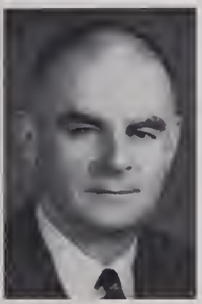
(Advertisement)

sive" rather than "liberalized." It leaves the choice of seeking a termination to pregnancy entirely up to the patient and does not force any doctor, nurse, or hospital to participate. "How much, how often, and who" shall have an abortion is entirely up to the conscience, judgment and medical ethics of a given hospital staff, Doctor Taylor said.

Compared to countries which have an extremely permissive abortion law, such as Japan or Sweden, the ratio of abortions to live births is very low, Doctor Taylor concluded.



DISCUSSING THE OTHER side of the coin — how to get pregnant and stay that way — was Herbert Horne, Jr., M.D., from the department of obstetrics-gynecology at Harvard Medical School. Speaking on "Infertility," Doctor Horne outlined the complicated process by which the male sperm reaches the ovum, thereby causing conception, and described some of the conditions which can prevent fertilization such as: Immunity of the female ovum to the male sperm, abnormal sperm formation in infertile men, tight tube openings in women, and insufficient sperm production on the part of the man.

Highlight of the second day of the conference was a discussion of the "Use of Rh Immunoglobulin in Hemolytic Disease of the Newborn," by John G. Gorman, M.D., director of the blood bank at the Presbyterian Hospital in New York City.

"If there is one point I would like to get across today," said Doctor Gorman, "is that the initial event which starts the disease has happened a year or more before the mother comes to the hospital."

Doctor Gorman, in conjunction with other researchers, has been able to prevent this disease event from occurring through the injection of Rh Immunoglobulin. He explained the problem arises when an Rh negative mother has an Rh positive child. In the last stages of her pregnancy, many of the Rh positive blood cells can pass into the mother's body. Her response will be to form antibodies to protect her blood stream against the incompatible cells. The danger comes when those antibodies are passed into the body of the child and attack his blood cells. Anemia, brain damage, jaundice, and still birth can result. Usually the first pregnancy would not be involved because the sensitization of the mother is most likely to occur at the time of delivery. Each additional pregnancy adds another 10% chance of developing sensitization in the mother.

To prevent the mother from forming antibodies in the latter stages of pregnancy, Rh immunoglobulin, called RhoGAM, is injected. RhoGAM is made from human plasma. "A sensitized mother that has had several stillborn babies is the best donor to help other mothers," says Doctor Gorman.

The immunoglobulin contains Rh antibodies which, for reasons which are not yet perfectly clear, prevent the mother from forming her own antibodies. The danger to subsequent children is present only when the mother is sensitized by Rh antibodies which she herself has produced.

Doctor Gorman explained further that the clinical breakthrough in the development of RhoGAM came in the early 1960s when a group of Rh negative prisoners at Sing Sing were tested. 18 of the prisoners were injected with Rh positive blood. 12 of them developed an immunity through the production of antibodies by their own bloodstream. The rest, injected with Rh positive blood and RhoGam, which already contained Rh antibodies, did not develop the immunity. This test proved that RhoGam could prevent the sensitization to Rh positive blood which is so dangerous when it occurs in child-bearing women.

Since then, clinical trials involving more than 3,000 women in 42 cities, including Ann Arbor, Grand Rapids, and Detroit, have been carried out with an astonishing degree of success. Manufactured by Ortho Pharmaceutical Company, approval of RhoGam by the National Institute of Health is expected in the very near future. □

MICHIGAN
STATE
MEDICAL
SOCIETY

NEW MSMS MEMBERSHIP

MSMS now has available a gold-filled Official MSMS Membership Pin for use in the coat lapel, as a tie tack, etc. Send check made out to MSMS for $3.00 to Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

MSU Reveals Plans For Medical Center

A citywide regional medical center, involving cooperative arrangements between Lansing area hospitals and a health center at Michigan State University, may be in Lansing's future, according to Andrew D. Hunt, Jr., M.D., dean of MSU's College of Human Medicine.

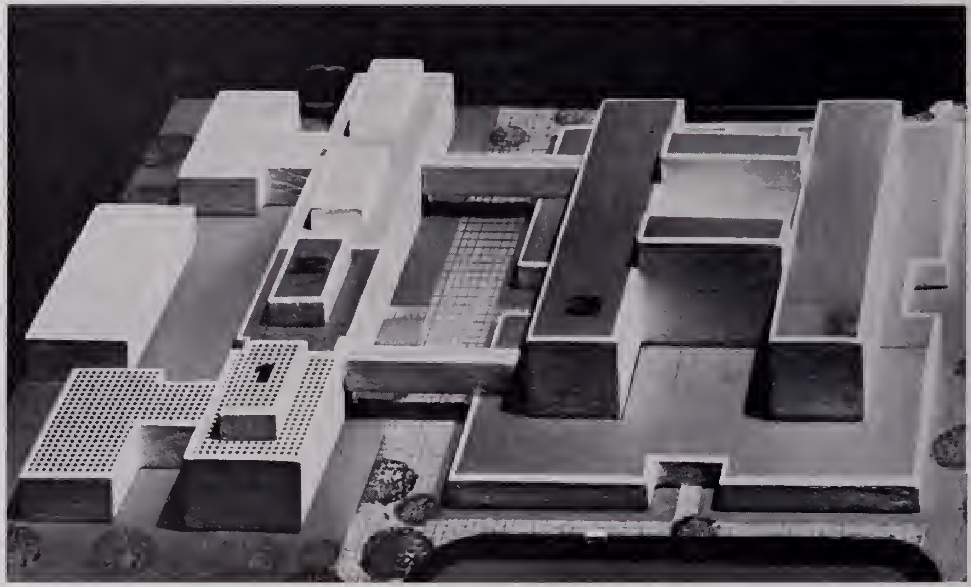
"This trend of the Lansing hospitals to develop as a medical center," said Dean Hunt at a Lansing Area Health Facilities Planning Council meeting, "suggests a model of cooperative community arrangements which will stimulate an increasing number of referrals from elsewhere, and strengthen the capacity of local physicians and hospitals to serve the community."

Through informal planning, Lansing hospitals have emphasized different areas of medicine, Dean Hunt said, so that "the opportunity exists for patients to be referred to one hospital or another for specific purposes."

The health center which MSU is planning, Doctor Hunt continued, will complement rather than duplicate specialized services already offered in the area. It will be located south of present campus buildings, between Hagadorn Road and Bogue Street extended.

First priority in the health center, he said, is a Life Sciences Building which will permit MSU to expand its current two year medical school enrollment from 26 to 64 students.

To become a four year medical degree-granting program two additional buildings will be needed — a Life Sciences II Building and the University Health Center Building.



The health complex for MSU, shown above, would include a Life Sciences Building (1) to permit MSU to expand its present two-year medical program from 26 to 64 students in each class, and would house the Department of Pharmacology and the School of Nursing, permitting expanded enrollments in these areas as well; Life Sciences II (2) to house additional science departments, and the University Health Center (3) would combine a hospital, an outpatient center and a student health service and would be designed specifically for teaching and research. Estimated costs are $10 million for Life Sciences I, $8 million for Life Sciences II and $15 million for the University Health Center. Half or more of the construction costs is potentially available in matching funds from the federal government. Unnumbered blocks represent a science library and possible additions to Life Sciences.

When it's more than a bad cold

your patient can feel better while she's getting better

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle
327-8

Reporting of Medical Evidence On a Social Security Disability Applicant

BY DAVID P. GAGE, M.D.,
LANSING

The Arthritides

There are many requests made to physicians for medical information either on a patient whom they have been seeing or one whom they will be seeing. The type of report given by any one physician is quite variable and the medical documentation of a case where the patient has applied for disability insurance benefits from Social Security need not follow any set pattern nor formula.

The reporting physician must decide in each particular case what facts need be obtained and reported to support his clinical appraisal of the patient's disease, the medical outlook for the future, and his ability to function.

Any attempt to follow an outline could be a poor replacement of the knowledge and art that permits a professional judgment.

History

If, however, one did wish to record rather completely the history of an individual with some form of arthritis, for example, he would recount in the description of present illness, the date of onset of initial symptoms, the rapidity of development and progression of symptoms including, where applicable, the characteristic of pain, swelling, fatigue, weakness, morning stiffness and limitations of motion that restrict the daily activities of the individual. Where the disease pattern remits and relapses this should be noted. Any associated symptoms such as fever, weight loss, fractures and loss of appetite would be relevant. It is often very helpful to know how well or poorly the patient has responded to drugs of various kinds. Previous clinical studies should be noted also.

The family history as well as the vocational history is often of great value, particularly the latter including a comment on his most recent occupation and ability to work regularly.

Physical Examination

The physical examination would, of course, follow the routine which the examining physician has established as his pattern but should be prefaced by noting patient's posture, gait, nutrition and the use of assistive devices. It is always helpful to have a positive comment on the status of the peripheral vessel pulsations and a routine neurologic exam including description of the mental state, sensory and motor functions, abnormalities noted, etc.

If one has need to describe certain joints the description should note presence of local heat, nodules and the condition of overlying skin and subcutaneous tissue. The associated muscle changes, especially the location and degree, can include notation of atrophy, spasms, contractures, etc. where present. If there is a change in joint size it should be related to the presence of fluid, bony overgrowth, thickening of joint membrane and degree of tenderness in the joint. Deformity and shortening of a joint is significant, as is the range of motion where limitation, particularly due to pain, ankylosis and spasm exists. Where joint mobility is involved some comment on the patient's ability to stand, walk, bend, stoop, crouch, sit, climb stairs, pinch, grip, reach, type, dress and undress, is in order.

Laboratory

In the laboratory area there would ordinarily be considerable variation, but a few basic tests which generally help are blood count, urinalysis, and x-ray of several involved joints. Some cases will require additional laboratory studies and the ones often very helpful are determination of rheumatoid factor, uric acid, the LE prep and antistreptolysin titre. Other blood chemistries can be extremely helpful, including BUN, calcium-phosphorus levels and the total protein with A/G ratio. The usual serology should be included,

---

Doctor Gage is Chief Medical Consultant, Disability Determination Service, Division of Vocational Rehabilitation, State Department of Education.

ECG and sometimes ventilatory function studies may be indicated.

Diagnostic, Prognostic and Functional Conclusions

If the examiner cares to submit an *anatomic* classification this can be coded as of a given stage (I - IV), and the *functional* classification can be graded from class 1 to 4, as provided by the American Rheumatic Association.

In subsequent contributions to the Journal I would like to touch on several other body systems in which a review of the supporting data might be helpful.

The treating physician plays a significant role in helping us to make disability determinations that are medically sound, and with our vocational evidence assure this patient an equitable decision. Our Social Security—Vocational Rehabilitation team can provide speakers to discuss the adjudication process and Social Security coverage for physicians. If your local society or group is interested, please call or write: Disability Determination Service, Division of Vocational Rehabilitation, Department of Education, Box 1200, Lansing, Michigan 48904; or phone area code 517-373-3380.

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

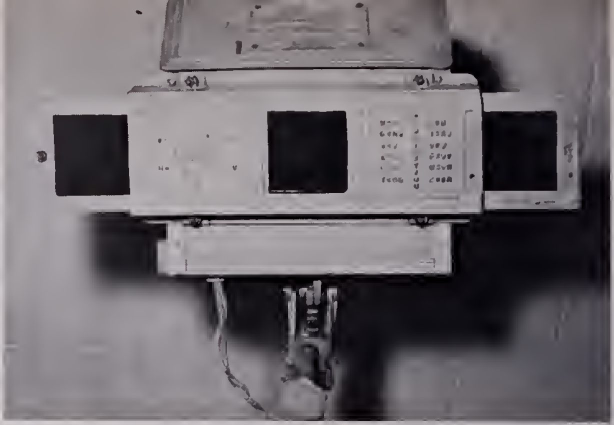
FOR THE FOUR-WEEK PERIOD ENDING MARCH 29, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	36	174	121	498
Whooping Cough	28	86	132	280
Diphtheria	0	0	0	0
Mumps	2,389	2,158	7,297	5,938
Scarlet Fever & Strep Sore Throat	1,414	1,856	4,098	5,620
Tetanus	0	0	1	0
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	140	154	461	625
Salmonellosis (Other than S. typhi)	72	47	166	150
Typhoid Fever (S. typhi)	0	0	0	1
Shigellosis	16	33	49	120
Aseptic Meningitis	9	1	18	4
Encephalitis	5	7	28	24
Meningococcic Meningitis	6	1	30	14
Influenzal Meningitis	3	0	14	9
Tuberculosis	262	284	775	795
Syphilis	371	596	1,416	1,612
Gonorrhea	1,186	1,474	4,161	4,030

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

All these items are declared medically worthless by the Food and Drug Administration. The "Slenderoll" supposedly helped roll off excess poundage. "Sea Brine," or minerally enriched ocean water, is an old favorite with swindlers. "Laetrile" was potentially more dangerous because it claimed to destroy cancerous cells. The "Electro-Galvanic" bracelet, selling for $22.50 "cured" sciatica and arthritis. "Visan," a nutritional food supplement, was recommended for "mental confusion, cerebral palsy, blindness, multiple sclerosis, diabetes, etc."



A notorious quack device, the "Spectrochrome" allegedly cured 150 major diseases with light from an ordinary light bulb shining through colored glass slides. Cancer was "cured" by moving purple and blue slides in front of the light; heart disease was "cured" by using the red and purple slides. Before its confiscation, some patients had died.

When You See a Quack - Tell Your Patients to Duck

Editor's Note: The following article is reprinted with permission from Highlights, the publication of Michigan Blue Shield-Blue Cross for employees. The article is printed here to provide physicians more information and insights into quackery, as MSMS moves during 1968 into a strong educational-quackery program across the state with component medical societies.

What is a quack? In defining the word, dictionaries use such synonyms as "fraud, faker, pretender, a practitioner of deceit." The medical quack is most easily described by what he is not.

The legitimate practice of medicine is carried on by men and women who have spent ten years or more in study and preparation. After leaving college they go to medical schools, then into hospitals for internship and postgraduate training where they are under the direction of highly trained and experienced instructors. The necessity of being sure, being right, testing again and again, seeking other informed opinions, questioning and searching is continually emphasized.

THE QUACK IS NOT a professional, neither in medical training nor in medical ethics. The outright criminal quack knows his medicine or treatment of whatever sort is worthless. He is out to milk money from persons who are ill, often with incurable diseases, and he does it without any qualm of conscience. It is his way of making a living and nothing more than that—from his point of view.

The quack lectures and travels and advertises, showing testimonials from "cured" patients—who probably did not have the disease to start with. He is usually glib in speech and affable in manner. He frequently displays forged licenses and diplomas.

USUALLY THE QUACK CLAIMS he can treat organic disease by a special secret method or by a certain product. He may pretend to have special cures for arthritis, diabetes, tuberculosis, cancer, feeblemindedness or other serious conditions. Believing only what they are told by a pitchman or health lecturer, millions of people each year attempt self-medication for their self-diagnosed symptoms. Countless more, some with confirmed illnesses, are beguiled with assurances of a quick cure, even for incurable diseases.

Honest medicine cannot always give such assurances. The quack, unhindered by professional ethics or personal concern, can and does promise cures he knows he cannot possibly deliver. Just as bad, the quack often negates much of the good that medicine can do or was doing. He steals pre-

Continued on 678

Is it depression?

She says "I'm always on edge..."

...but her other symptoms:
depressed mood, insomnia, anorexia, feelings of guilt
strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

MSD **MERCK SHARP & DOHME** Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

cious time—that early period of a disease when prompt, efficient treatment can easily mark the difference between life and death.

Today quackery is a big business. Accurate figures are difficult to obtain, but experts estimate that Americans spend ONE BILLION DOLLARS each year (45 million dollars in Michigan alone) on useless cures, mechanical gadgets, fad foods and other quack remedies.

The solution to the quackery trade is not simple. In fact, the prosecution of frauds perpetrated in the guise of medicine is extremely difficult. Just as a hypochondriac imagines disease, so can the gullible unthinking person imagine cures, even when disease still exists.

TO HELP THE PUBLIC spot quacks, the U. S. Food and Drug Administration in Detroit offers this check list of six points. He is probably a quack if:

1. He uses a special or "secret" machine or formula he claims can cure disease.
2. He guarantees a quick cure.
3. He advertises case histories and testimonials to promote his cure.
4. He clamors constantly for medical investigation and recognition.
5. He claims medical men are persecuting him or are afraid of his competition.
6. He tells you that surgery or x-rays or drugs will cause more harm than good. ☐

Michigan Statistics Re The Health Team

* Number of Graduates of Programs in Selected Health Professions, 1966

263	Medicine and Osteopathy
143	Dentistry
1,278	Nursing, RN, Total
244	Nursing, Baccalaureate
876	Nursing, Diploma
158	Nursing, Associate
1,479	Practical Nursing

* Graduates of Programs in Selected Health Professions per 100,000 Population

8,374	Population 1,000's
3.1	Medicine and Osteopathy
1.7	Dentistry
15.3	Nursing, RN, Total
2.9	Nursing, Baccalaureate
10.5	Nursing, Diploma
1.9	Nursing, Associate
17.7	Practical Nursing

* Public Health Service Publication, #1667 *"Health Manpower, Perspective 1967"* U. S. Government Printing Office, 55¢

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road Conducted by Sisters of Mercy Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

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* 1904 - 1967

SPECIAL FOUR-PAGE SECTION:

Explain Efforts of Michigan Council on Smoking and Health

The Surgeon General's Office of the United States Public Health Service has recently released a three-year follow-up on smoking and disease entitled, *The Health Consequences of Smoking.* The 1967 report represents a review of more than 2,000 research studies published since the 1964 report.

These additional studies confirm and strengthen the conclusion of the Surgeon General's Advisory Committee that: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."

SINCE THE RELEASE of the Surgeon General's Report on Smoking in 1964, some progress has been made in educating Americans, especially the young, to the dangers of smoking. The progress has been in the following areas:

1. Seven out of ten people know smoking is a health hazard.
2. There are 19,000,000 ex-smokers.
3. One million people quit each year. (Unfortunately these are, roughly, replaced by youth who take up the practice.)
4. One-fourth of the men and one-fifth of the women who once smoked have quit.
5. One-third of those who try to quit do make it.
6. The percentage of physicians who smoke has dropped from 60 in 1960 to less than 25 now, in 1967.
7. Some college project directors report less smoking among entering freshmen than in past years.
8. Recently federal tax administrators said that the 2.5 per cent increase in cigarette sales last year reflected little increase in per capita cigarette usage and that per capita consumption had declined in twenty-two states and the District of Columbia.
9. Some insurance companies now are giving lower rates to nonsmokers.
10. Several magazines no longer accept cigarette advertising.
11. A few airlines have stopped distributing cigarettes with meals.

IN MICHIGAN, MUCH of this work is being carried out by the Michigan Council on Smoking and Health and its 16 member agencies and organizations. The Michigan Council on Smoking and Health is an active interagency organization concerned with focusing public attention on the problem of cigarette smoking and disease and coordinating the efforts of its member organizations. As a physician, you are probably familiar with most of these organizations and may have served these organizations as a resource person or board member. The sixteen organizations are:

1. Michigan State Medical Society
2. Michigan Youth Commission
3. Michigan Association of Secondary School Principals
4. Michigan Cancer Foundation
5. Michigan Congress of Parents and Teachers
6. Michigan Department of Education
7. Michigan Department of Public Health
8. Michigan Education Association
9. Michigan Health Council
10. Michigan Heart Association
11. Michigan School Health Association
12. Michigan School Nurses Association
13. Michigan State Dental Association
14. American Cancer Society—Michigan Division
15. Michigan Tuberculosis and Respiratory Disease Association
16. Michigan Association of Osteopathic Physicians and Surgeons

THE OBJECTIVES OF the Michigan Council on Smoking and Health are:

1. To coordinate, when appropriate and desirable, the smoking educational programs of organizations interested in smoking and its relationship to health and disease;
2. To promote and assist where appropriate in the development of regional and local councils in Michigan;
3. To promote education as the primary means of favorably influencing youth and adults regarding their decisions on smoking;
4. To stimulate the production and utilization of appropriate resource materials;

5. To encourage the utilization of research and research findings in all areas related to the impact of smoking on health and disease;
6. To collect and disseminate factual information about the relationship of smoking to health and disease.

THE MICHIGAN COUNCIL on Smoking and Health is concerned primarily with public education. Key groups that the Michigan Council is trying to reach are youth, parents, teachers and physicians. Local programs that you should be alert to in 1968 are cooperative programs with:

1. **YOUTH:** Cooperative project with the Michigan Youth Commission, the official governmental agency representing the 41 major youth-serving agencies and organizations. YAC — Youth Advisory Committee — of the Michigan Youth Commission is interested in a youth-to-youth program to discourage smoking among young people.
2. **PARENTS:**
   a. COOPERATIVE PROJECT WITH PTA: Cooperative project with Michigan Congress of Parents and Teachers — second year. Last year, we completed Phase I of the National PTA Parent to Parent Program that was concerned with *orientation* of parents to the smoking and health problem among youth. This year the emphasis will be upon developing action programs among local PTAs in reducing the incidence of smoking among young people.
   b. COOPERATIVE PROJECT WITH CHILD STUDY CLUBS: Assisting the state organization to develop a study resource unit on smoking and health that can be used by all Child Study Clubs in Michigan.
3. **TEACHERS:** Cooperative project with Michigan Department of Education. Implementation of National Education Association program to strengthen health education instruction in the school with emphasis upon the problem of smoking and health.
4. **PHYSICIANS:**
   a. MICHIGAN STATE MEDICAL SOCIETY: The Michigan State Medical Society Public Relations Committee is charged with responsibility of studying the problem of smoking and health and making recommendations for action to the State and County Medical Societies.
   b. MICHIGAN ACADEMY OF GENERAL PRACTICE: Request to assist the Michigan Academy in organizing a series of one-day workshops on the topic of smoking and health. Physicians attending would receive Category I credit.

SPECIFICALLY, WHAT CAN you do as an individual in this state-wide program to reduce illness and disability connected with cigarette smoking:

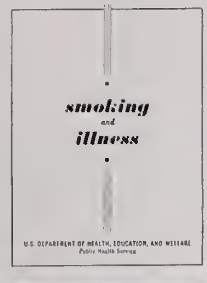
1. Familiarize yourself with the latest information on smoking and disease and the most effective techniques for discouraging smoking;
2. Make a motion that your local county medical society have a program on smoking and disease; and
3. Assist groups in your local community like the PTA and youth-serving agencies in carrying out educational programs on smoking and disease.

AS A FIRST STEP, we urge you to look over the materials available for physicians and patients on this topic which are illustrated on the next page and available to you without cost. Please indicate the materials that you want and the quantity desired on the attached self-addressed, stamped postcard.

The Michigan Council on Smoking and Health is actively engaged in promoting smoking education through programs of

— In-school information
— Withdrawal clinics
— Circulation of films
— Materials
— Workshops for teacher education
— Establishment of local councils
— Media information for Press, Radio, TV

THESE EIGHT ARE ESPECIALLY FOR THE PHYSICIAN . . .


smoking and illness

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

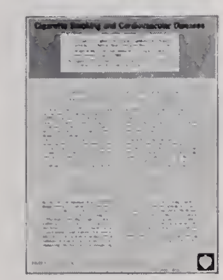
1. Smoking and Illness

U.S. Public Health Service
Pamphlet summarizing survey conducted by National Center for Health Statistics on relationship between cigarette smoking and general health.

THE FACTS about Smoking and Health

2. The Facts About Smoking and Health

U.S. Public Health Service
A pamphlet summarizing the results of the new Surgeon General's Report of 1967 on smoking and health.


Cigarette Smoking and Cardiovascular Diseases

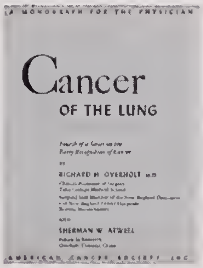
3. Cigarette Smoking and Cardiovascular Diseases

Michigan Heart Association
A reprint summarizing the American Heart Association Scientific Committee study of the smoking and health problem.

LUNG CANCER PREVENTION AND THE PHYSICIAN

4. Lung Cancer Prevention and the Physician

A pamphlet summarizing statisti-
American Cancer Society—Mich. Div.
cal data on the relationship of cig-
arette smoking to lung cancer.


A MONOGRAPH FOR THE PHYSICIAN

Cancer OF THE LUNG

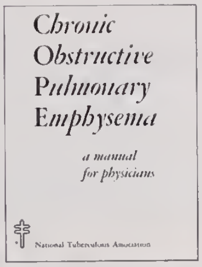
RICHARD H. OVERHOLT M.D.

SHERMAN W. ATWELL

AMERICAN CANCER SOCIETY, INC.

5. Cancer of the Lung

American Cancer Society, Mich. Div.
A 52-page monograph for physicians on diagnostic procedures for early recognition of lung cancer.

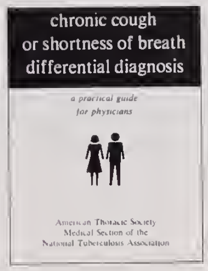

Chronic Obstructive Pulmonary Emphysema

a manual for physicians

National Tuberculosis Association

6. Chronic Obstructive Pulmonary Emphysema

Michigan Tuberculosis and Respiratory Disease Association
A 56-page manual for physicians on diagnosis and treatment of this disease.

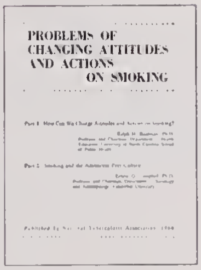

chronic cough or shortness of breath differential diagnosis

a practical guide for physicians

American Thoracic Society
Medical Section of the
National Tuberculosis Association

7. Chronic Cough or Shortness of Breath — Differential Diagnosis

Michigan Tuberculosis and Respiratory Disease Association
A 14-page pamphlet for physicians on differential diagnosis of this problem.


PROBLEMS OF CHANGING ATTITUDES AND ACTIONS ON SMOKING

8. Problems of Changing Attitudes and Actions on Smoking

Michigan Tuberculosis and Respiratory Disease Association
A pamphlet with concrete suggestions for getting patients to stop smoking.

Michigan Council on Smoking and Health:

Gentlemen:

Yes, I want copies of your publications on smoking and disease. I understand the publications will be furnished at no charge by the member agencies of the Michigan Council as part of the public educational effort.

Please send me the following materials I have checked in the quantity requested to:

NAME____

STREET______________________________________

CITY____________________________ZIP__________

☐ 1 ________
☐ 2 ________
☐ 3 ________
☐ 4 ________
☐ 5 ________
☐ 6 ________
☐ 7 ________
☐ 8 ________
☐ 9 ________
☐ 10 ________
☐ 11 ________
☐ 12 ________
☐ 13 ________
☐ 14 ________
☐ 15 ________
☐ 16 ________

THESE CAN BE DISTRIBUTED TO PATIENTS . . .

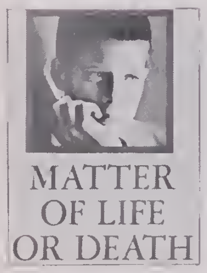
100,000 doctors have quit smoking cigarettes.

9. Poster for Physician's Office

(100,000 Doctors Have Quit Smoking)
U.S. Public Health Service
An attractive 8½ x 11 inch black and white poster suitable for display in physician's office.

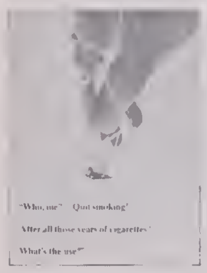
10. What We Know About Children and Smoking

U.S. Public Health Service
A pamphlet describing why children start smoking and what adults can do so help children from starting.



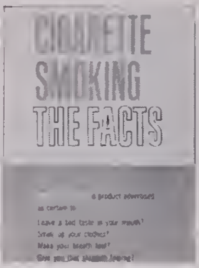
11. A Matter of Life or Death

Michigan Congress of Parents & Teachers
A pamphlet explaining the dangers of cigarette smoking for young people and what parents can do.



12. Who Me? . . . Quit Smoking?

American Cancer Society—Mich. Div.
A pamphlet explaining why an adult should stop smoking and what can be done to "kick the habit."



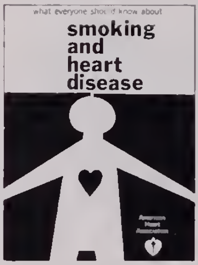
13. Cigarette Smoking — The Facts

Michigan Tuberculosis and Respiratory Disease Association
A pamphlet discussing the health hazards of smoking, why people go on smoking, and what can be done about this problem.

the Great Imitators

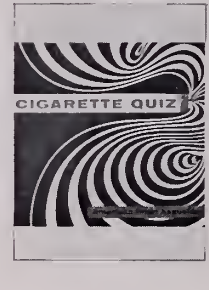
14. The Great Imitators

American Cancer Society—Mich. Div.
A pamphlet showing how children imitate parents' smoking behavior and what parents can do to discourage this practice.



15. Smoking and Heart Disease

Michigan Heart Association
A pamphlet showing the relationship between cigarette smoking and heart disease.



16. Cigarette Quiz

Michigan Heart Association
A pamphlet testing your I.Q. on smoking with answers and discussion for each question.

Doctor, please send this easy order blank to:

MICHIGAN COUNCIL ON SMOKING AND HEALTH
% MICHIGAN HEALTH COUNCIL
712 ABBOTT ROAD
EAST LANSING, MICHIGAN 48823

★

Specialized Service

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Vacation trip....

Motion sickness?

This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

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Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

BY H. A. TOWSLEY, M.D.
PRESIDENT, MICHIGAN HEALTH COUNCIL

Michigan Health Council Stresses Health Careers

The approach of Florence Nightingale's Birthday (May 12) and National Hospital Week (May 12-18) focuses attention on the need for more nurses and other health personnel.

There is scarcely a hospital, nursing home or medical center in the United States that is without a "Help Wanted" sign. These health care institutions are having to make do with the trained personnel they have or are recruiting from each other short-in-supply health personnel.

In spite of the nation-wide effort to promote careers in health and the thousands of articles that have appeared in newspapers and magazines in recent months, there still are many misconceptions about careers in health. I would like to address myself to some of them.

Entering a health occupation means being a physician or nurse.

This is no longer true. A century ago about 91 out of every 100 persons in a health profession were doctors of medicine, now the picture has changed completely and only nine out of every 100 persons presently engaged in health services is a physician. There are more than 300,000 physicians and over 3,500,000 men and women involved in health services in the United States. Thirty-seven of every one hundred are in other kinds of professional and technological health careers such as dentistry, pharmacy, nursing, medical technology, etc.; about the same number are in service and maintenance health occupations; and the remaining seventeen are administrators and office workers in hospitals, etc.

The Health Service Industry is America's fastest growing industry. There now are more than 200 job classifications, and new careers join the list every year. A generation ago, we had not heard of careers in inhalation therapy, nuclear medical technology or hospital unit management. What's more, the old health careers have taken on a new look. Many nurses today do not see the inside of a hospital except when they, themselves, are sick. Thousands are working full time as school nurses, industrial nurses, public health nurses and home care nurses with visiting nurse associations. Hundreds of nurses serve on faculties in Michigan community colleges training student nurses.

Many young men and women finishing training in veterinary medicine and pharmacy are going into research or pharmaceutical sales rather than following the customary procedure of a generation ago of practicing their profession in farming areas or in a corner drug store.

A minimum of a bachelor degree now is necessary preparation for a health career.

Not true. Health careers are so varied that education needed to enter them is varied, too, ranging all the way from a high school education to several years of post-graduate study. Here are some examples of careers requiring less than four years of college.

The nurse aide, orderly or psychiatric attendant can receive on-the-job training which may take up to three months. They perform many routine tasks of patient care, thus relieving the nursing staff for more complex duties.

The licensed practical nurse, the inhalation therapist, the electrocardiograph technician, and the surgical technical aide receive special training for their positions. This training usually is completed in one year.

Training in many careers in medical and dental offices as well as in hospitals may be obtained in two years or less. The certified laboratory technical assistant needs a high school education plus a year's training in an approved school. The medical assistant and dental assistant may obtain their training in one to two years. Dozens of other health occupation curriculums are in the one-to-two-year programs.

"I can't get the training I want here in Michigan."

False. Michigan has been a leader in developing new health occupations education programs, and there now are more than 50 health career curriculums being offered in 116 Michigan universities, colleges and hospitals. These careers range from that of an anatomist to a Vocational Rehabilitation Counselor. Let's take a look at what education programs Michigan now offers the young men and women seeking a career in health.

The Big Three in Education in Michigan also are the Big Three in providing medical and allied health curriculums. The University of Michigan now offers 25 different educational programs in medical, dental and allied health careers while Wayne State University with 20 and Michigan State University with 18 are close behind. All three now offer programs in medicine, nursing, medical technology, biology, dietetics, anatomy, audiology and speech and hearing therapy. Both the University of Michigan and Wayne State University train physical therapists and pharmacists while Michigan State University is the school in Michigan training veterinarians.

The University of Michigan and the University of Detroit are among the largest schools of dentistry in the United States and also train most of the dental hygienists in Michigan. Ferris State College is next in line in providing health career curriculums in pharmacy, dental assisting, dental hygiene, environmental health sanitation, environmental health assisting, food technology, medical assisting, medical technology, optical technology, radiologic technology. Several new health career curriculums such as associate degree nursing, medical record technology, radiation health technology and pesticide technology are being scheduled at Ferris for the Fall of 1968.

Students interested in medical technology may obtain their preparation in every area of Michigan, because there are 50 different colleges and hospitals that provide classroom and clinical facilities for this profession. Among the schools adding new health careers curriculums during the past five years are such state universities and colleges as Eastern, Western, Central, Michigan Technological and Lake Superior State College and such privately supported colleges as Alma, Olivet, Mercy and others. Northwood Institute at Midland is pioneering a new health curriculum known as the hospital unit manager program. This two-year curriculum will enable hospitals to have a well-trained person take over many of the non-nursing functions in the hospital thus permitting registered nurses to spend a greater share of their time on patient care.

"I can't afford an education for a health career."

Not true. A student who really has the desire and qualifications to become a doctor or a member of one of the other health professions can attain his or her goal regardless of his financial situation. There are many voluntary organizations such as the United Cerebral Palsy Association that provide loans and scholarships for students interested in rehabilitation careers, and loans and scholarships for students in need of financial help also are available through our colleges, hospitals and other institutions.

The AMA offers a splendid loan program for medical students, and tens of thousands of young doctors have obtained their training through this program.

The State of Michigan and the Federal Government now offer loan and scholarship programs for students taking many of the health occupations. Students can start repaying the loan after they finish their education and in some programs as much as half of the loan will be written off if the person practices his profession for five years or longer. The C. S. Mott Foundation of Flint will provide funds for young men and women in Michigan's Upper Peninsula who want to go to medical school but need financial assistance because of family circumstances. The Foundation also will help students in some of the other health occupations.

The Michigan Health Council will be glad to assist students interested in exploring the availability of scholarship or loan funds, or the student may communicate directly with his guidance counselor or the college, hospital or other institution they contemplate attending to learn of available financial aid.

"I don't know where to write for health careers information."

The Michigan Health Council, P. O. Box 431, East Lansing, Michigan 48823, will provide any Michigan young person, counselor or other interested individual with a free copy of "Horizons Unlimited," a publication of the American Medical Association telling about most of the health occupations. Through the cooperation of MHC and the Michigan State Medical Society, a special section lists all of the health occupations taught in Michigan and explains where a student may obtain his training. It also lists professional organizations that can provide detailed information on health occupations, scholarships, etc.

"Health Careers Guidebook" is another splendid publication. It is available for $1.50 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. This book contains briefings on more than 200 different health careers, with addresses to which to write for further information.

A great deal of information on both professional and practical nursing is available from the Michigan League for Nursing, 51 West Warren, Detroit, Michigan 48201.

ONE MORE MISCONCEPTION – perhaps the most subtle of all – remains concerning health careers. It is the idea that as more and more new machines, drugs, devices and techniques are developed in the field of medicine, health personnel somehow become less important. Nothing is farther from the truth. We can't program computers to be concerned about human beings. More than ever before, we need people in the health professions who have compassion and sympathy for others, who really care enough about those they help to get involved and provide them with the best possible health care and services. ☐

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

Says Programs In Sex Education Need MD Support

"The support of the medical profession is needed as local boards of education explore the needs and develop K-12 programs in sex education," declared Frederick J. Margolis, M.D., Kalamazoo, in his remarks at a recent meeting in Midland with leaders of the Midland County Medical Society.

Doctor Margolis narrated his film, "Parent to Child about Sex" and led discussion for 500 parents and teachers at an evening community program.

Doctor Margolis observed that a school board will have difficulty moving forward in sex education without the support of the local physicians and medical society.

"Communities interested in improving sex education," Doctor Margolis said, "can establish a large, representative 'Community Council for Sex Education.' " "Sex education," he said, "must be a responsibility of the home and church, but the schools provide the best opportunity to work effectively with all children. Hand-in-hand with better school programs, with the teachers assigned to build the curriculum, there should be adult education classes, workshops, etc.," he declared. ☐

STATE ANESTHESIOLOGISTS SELECT LEADERS

Shirley Austin, M.D., Detroit, is the new Chairman of the Michigan Society of Anesthesiologists. John F. Coleman, M.D., Traverse City, was elected vice-chairman and Ralph Bauer, M.D., Detroit, was re-elected secretary-treasurer.

The officers also serve as Section Officers in the Section of Anesthesiology.

Ralph Askam, M.D., Muskegon, is the delegate to the MSMS House of Delegates and Bernard Sivak, M.D., Southfield, is the alternate delegate for 1968 and 1969. ☐

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

RPIDINE
PARGYLINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
ENDURON
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

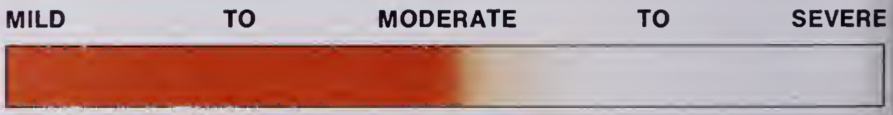
Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension

DESERPIDINE
METHYCLOT
ZIDE
100 No. 6830
Tablets (Grooved)
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

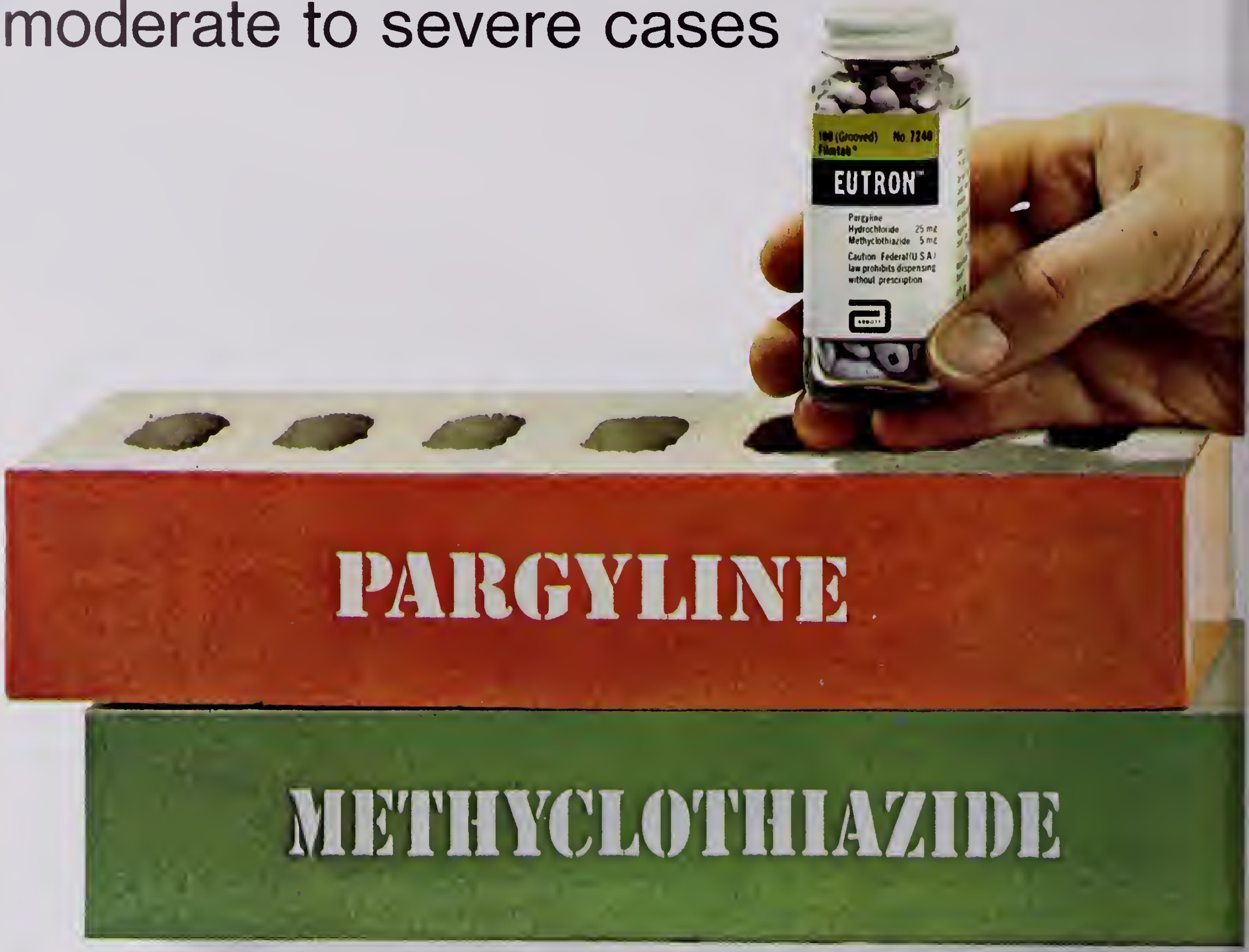
ETHYCLOTHIAZIDE 5 mg. with
ESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON™
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution: Federal (U.S.A.) law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Beaumont Lecturer Explores the Brain

BY PETER HOHEISEL
OF THE MSMS STAFF

Pacing the platform of the Wayne County Medical Society auditorium and showing slides of monkeys and chimpanzees, José M. Delgado, M.D., 1968 Beaumont Lecturer, fascinated an audience of 300 people April 1 with the topic "Reaching for the Mind in the Depth of the Brain."

After tracing the erosion of the concept of man's earth as the center of the universe, man's race as a unique creation totally distinct from the other animals, and finally man's ego as a pre-existent, inwardly-given reality, Doctor Delgado expounded his thesis that "Today we can approach the mind; it isn't some mysterious, unreachable entity but rather it is memory, pleasure, and pain. All of these, and other mental functions, should have neural coordinates which we can investigate and modify."

The Yale physiologist has been investigating the brain, mainly in monkeys and chimpanzees, through the use of electrodes implanted in specific cerebral areas. He has developed what he calls the "Stimo-ceiver" which can both monitor and modify brain activity. In the slides of monkey and chimpanzee activity, Doctor Delgado illustrated how he can induce, through radio waves, aggression, friendliness, maternal rejection, running, and other physiological patterns.

"HOW IS BEHAVIOR organized in the brain? Where is anger? Love? Where are ideas? Emotions?

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

These are the questions we are investigating," said Doctor Delgado.

"The neurophysiologist, however, must realize the limitation of what he is doing," Doctor Delgado cautioned. "We can only detect the material carrier of the information, not the symbolic meaning. Symbolic meaning depends on the process of cultural formation. The meaning that a glass is a glass is given by experience based on a temporal quality."

Speaking of his experiments with monkey and chimpanzee colonies, the Yale physiologist observed that "you can't talk of brain stimulation in absolute terms, but only in relation to the social group." He said stimulation can only affect preexistent patterns. It cannot create new ones. For example the number two monkey in a colony could be induced to be aggressive to number one, but a money who is lowest in social rank could not successfully challenge the authority of number one.

DOCTOR DELGADO CONCLUDED that up to now man's technological prowess has been devoted to conquering nature outside of himself: "We haven't tried to put the same energy into conquering our minds and our brains. The challenge of the future is the education of our minds and psyches."

When asked, however, whether human beings could be turned into robots through radio stimulation, the Yale physiologist replied that he did not think this was possible since the mind which invents instrumentation is infinitely more complex than the devices which it creates. □

Ask Physicians Help July 1 in VD Survey

All practicing physicians in Michigan and the nation will receive a federal questionnaire mailed on July 1 as part of a National Survey of VD Incidence.

In an effort to obtain an accurate measure of the severity of the VD problem in the United States, the AMA, the National Medical Association, the American Osteopathic Association and the American Social Health Association in cooperation with the Public Health Service will conduct the "National Survey of VD Incidence," which will cover the period from April 1 through June 30, 1968.

The tabulated results will be published nationally by the sponsoring organizations.

All medical societies have been requested to cooperate by urging physicians to participate in this survey. □

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Phenobarbital, Caution: May be habit forming... 21 mg.
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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

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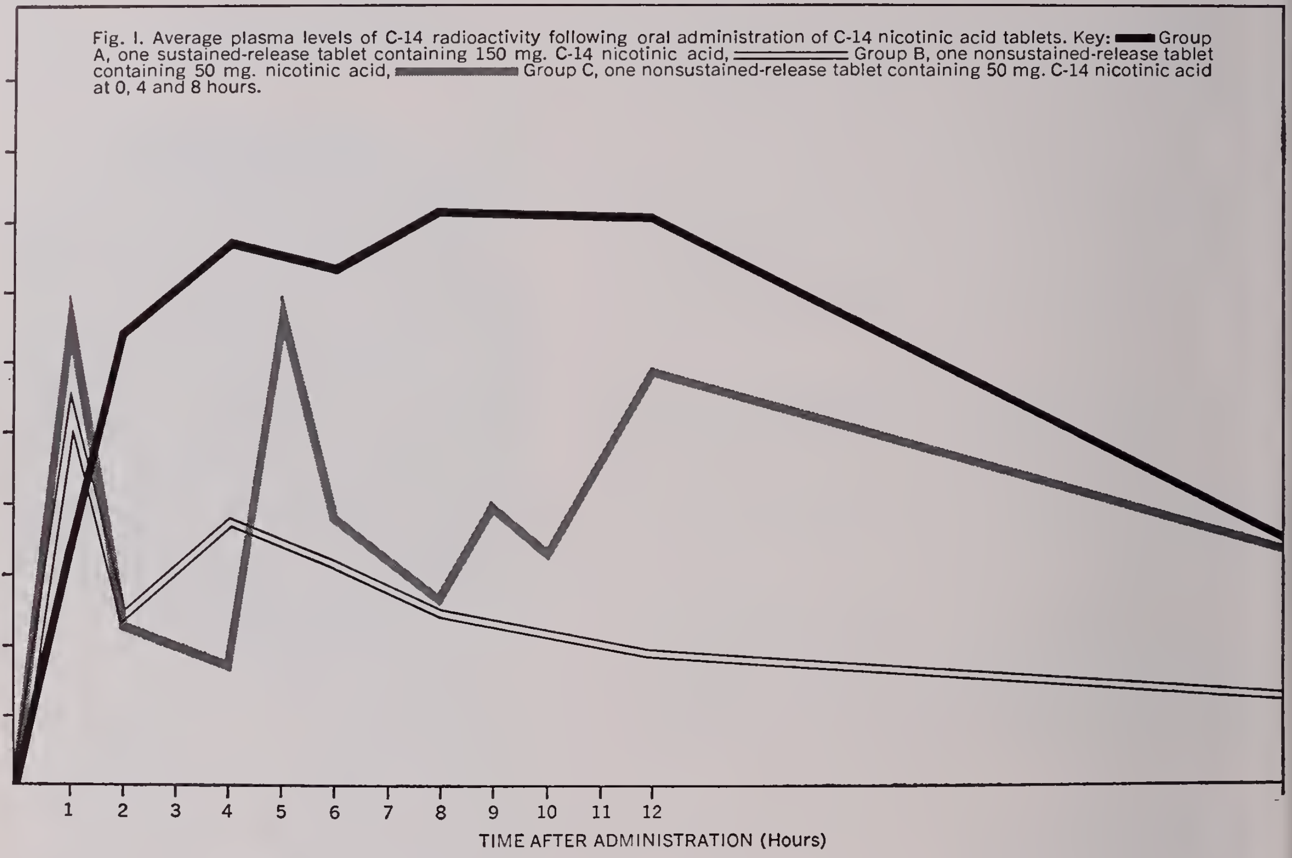
Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

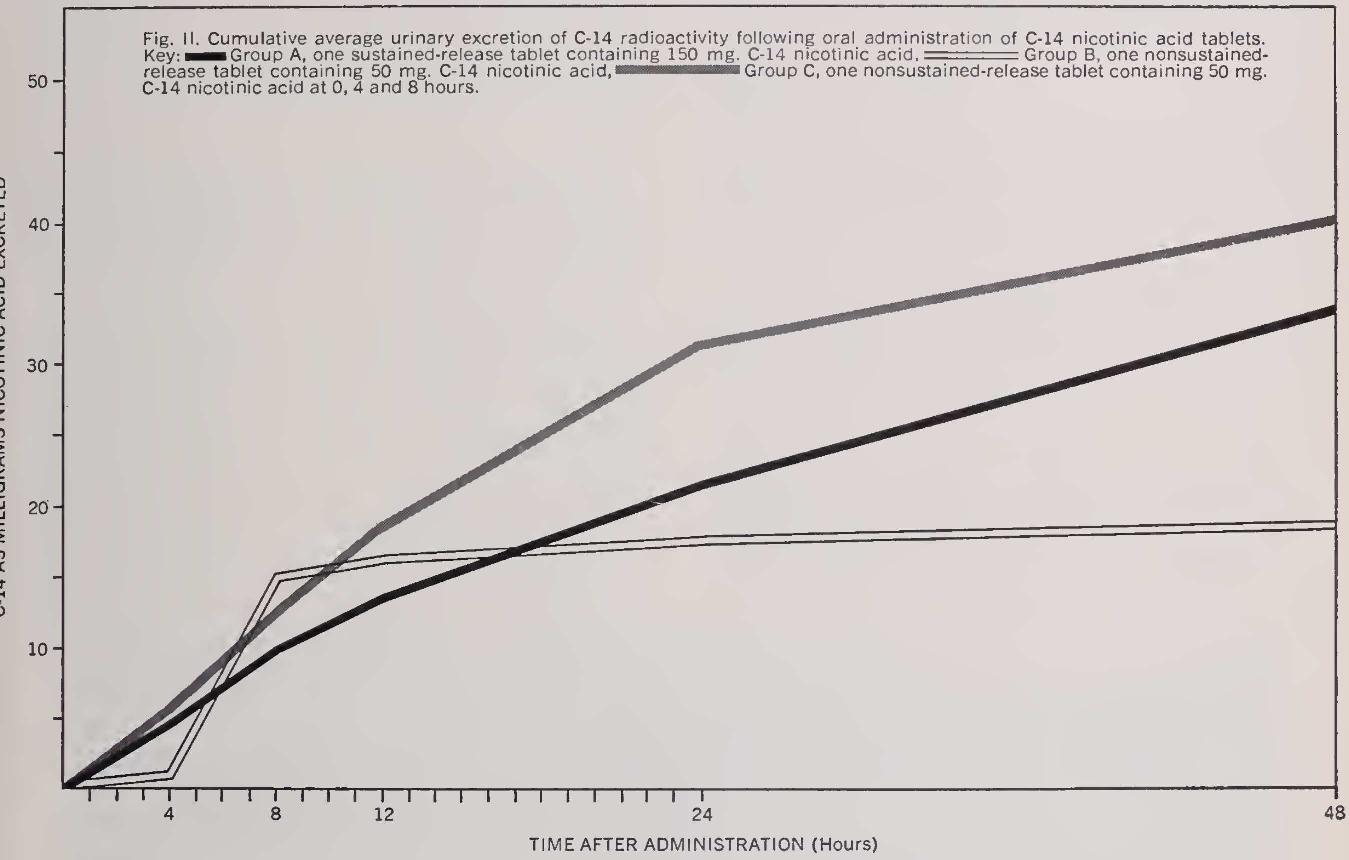

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Some Questions and Answers About Hospital Accreditation . . .

Q. In a community with two nonteaching hospitals, with exactly the same staff in each hospital, would the Joint Commission consider joint sectional staff meetings, in order to help alleviate some of the demand put on physician's time?

A. While the Joint Commission is interested in conservation of physician time, the purpose of hospital staff or departmental or sectional meetings is to review the clinical work of that particular unit. While the staff membership may be the same, the clinical case content is not and can hardly be pooled or exchanged.

Several local medical societies have developed schemes for coordinating individual hospital staff meetings with the medical society meeting. This extends the time of the end to end meetings, but reduces the number of occasions. For example, if the hospital staff members were to meet an hour or two early before the regular monthly medical society meeting, they could review the work done in one hospital one time and the other the next. The place is not so important as that the attention be exclusively on the given hospital's clinical work.

Q. If over age 65 patients constitute a large part of total deaths, with the attending difficulty in getting permission for autopsy, will the requirement of 20-25 per cent autopsy rate still prevail?

A. As the standards are presently written, the answer is yes: 20 per cent in nonteaching, 25 per cent in teaching hospitals. However, the main intent is to enhance continuing education of the medical staff. Autopsies in all or most of the deaths representing interesting cases, unsolved diagnostic problems and the like are more important than 20 per cent of all hospital deaths, if the 20 per cent consists of routine and similar cases. Also, the doing of an autopsy is only the vehicle. More significant is the actual discussion

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This question-and-answer page was developed by the Ohio State Medical Association in collaboration with the Joint Commission on Accreditation of Hospitals, John D. Porterfield, III, M.D., Director. Permission to reprint was granted by the Ohio medical society journal.

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"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Thiamine HCL ....10 mg.
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Each Tablet Contains:
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Glutamic Acid .... 50 mg.

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between the clinician and the pathologist about the clinical diagnoses and pathological findings involved. This standard is presently under serious review to see whether the objective can be better achieved by revision. Suggestions?

Q. With the availability of automated typewriters, will it be permissible for staff physicians — surgeons and radiologists, for example, to dictate a normal or standardized report in the case of a normal or routine procedure?

A. Yes, some hospitals now provide some form of automatic typewriter or even computer, and the Joint Commission does not object to their use as a form of dictation shorthand. It is essential only that the report be verified as correct and applicable by the author — the surgeon or radiologist, by his signature. There is concern, however, that this short cut not take the place of cortical activity by the physician involved. Check-off lists for history-taking and physical-examination recording often demonstrate this mouse-trap, where the hurried writer checks a box without conscious thought of what the record then says. It is disconcerting to see the entry on a chart: "Blood Pressure — Yes." Comforting, but not informative.

Q. Why has the Joint Commission not seen fit to explore or establish state-level representation?

A. If by this is meant representation on the Board of Commissioners, concerned interests are represented by seven commissioners named by the American Medical Association, seven by the American Hospital Association, three by the American College of Surgeons, three by the American College of Physicians (and now one by the American Association of Homes for the Aging and one by the American Nursing Home Association since extended care facilities are offered accreditation services). Quality of care does not vary from state to state and the volume of work in any one state usually does not warrant a related state-level representative group. Have I missed the point?

Q. Does the Commission have a concern about the increasing responsibility and dependence being placed on the licensed practical nurse?

A. The Joint Commission recognizes the substantial contribution to nursing personnel resources made by the licensed practical nurse. It recognizes, however, that she must be utilized within the limits of her license and the nursing services must be under the supervision of registered professional nurses. JCAH standards still call for constant (24 hours, 7 days) coverage of the nursing program by RN's and some hospitals have lost accreditation through failure or inability to provide this.

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IN MEMORIAM

I. M. Altshuler, M.D., Southfield

Ira M. Altshuler, M.D., Southfield psychiatrist, died March 17 at the age of 74. Doctor Altshuler was a member of the Southfield School Board from 1960 through 1964 and was active in other civic activities.

Doctor Altshuler was born in Russia and received his medical education at the University of Berne, Switzerland, graduating in 1917. He came to Detroit in 1920, and in 1927–28 he did postgraduate work at Harvard.

He was affiliated with the Wayne County General Hospital, Eloise; Glen Eden Hospital, Warren; Ardmore Acres, Farmington; and St. Clair Hospital, where he had served as chief of staff.

He was a Life Member of the Michigan Psychiatric Association, the Michigan Society of Neurology and Psychiatry, and MSMS. He was a member of the American Geriatric Society.

Doctor Altshuler, whose hobbies included composing music, was instrumental in the use of music in the treatment of psychiatric patients. He was director of the Group-Music Therapy Department at Wayne County General Hospital and an Honorary Member of the National Association for Music Therapists.

R. G. Axelrod, M.D., Royal Oak

Robert G. Axelrod, M.D., Royal Oak, died March 12. He was 45.

Doctor Axelrod was graduated from the Wayne State University School of Medicine in 1946 and interned at Wayne County General Hospital. He served as a captain in the U.S. Army Medical Corps from 1948 to 1950.

With his wife, Mildred Axelrod, M.D., and family, he did medical work in Afghanistan from January 1963 to January 1964. In June 1967 he went to Israel and travelled through the country treating the wounded.

Doctor Axelrod was a Fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine. He played French horn in the Jewish Center Symphony.

G. L. Brody, M.D., Ann Arbor

Gerald L. Brody, M.D., University of Michigan Medical School professor of pathology, died March 31. He was 42.

Doctor Brody attended Oberlin College, Oberlin, Ohio, and received the M.D. degree from Western Reserve University Medical School in 1949. He served in the medical branch of the U.S. Army for two years. He was affiliated with the University of Michigan Medical Center in Ann Arbor.

His hobbies included orinthology, photography, and fly-tying.

Doctor Brody was a member of the International Academy of Pathology and Phi Delta Epsilon fraternity.

J. T. Ferguson, M.D., Traverse City

John T. Ferguson, M.D., director of the geriatrics program at the Traverse City State Hospital, died March 1. He was 59.

Doctor Ferguson received his M.D. degree from the Indiana University medical school in 1948. After three years of general practice in Hamlet, Indiana, he was a resident at Logansport State Hospital, Logansport, Indiana.

He joined the staff of the Traverse City State Hospital in 1955 and participated in early research into the use of tranquilizers and other drugs in the treatment of the mentally ill. He published several articles in medical journals, and a book entitled "A Man against Insanity" was based on his life.

He was a Fellow of the American Geriatric Society and a member of the American Psychiatric Association, the American Association for the Advancement of Science, and Phi Chi fraternity.

Howard Havers, M.D., Detroit

Howard Havers, M.D., retired Detroit physician, died March 3 at the age of 77.

Doctor Havers, a Life Member of MSMS, had practiced in Detroit from the time of his graduation from the Detroit College of Medicine and Surgery in 1913. His internship was served at Grace Hospital and he remained a member of staff there, specializing in internal medicine.

For many years he served as a medical examiner for the draft board.

He was born in Sarnia, Ontario, and attended the Sarnia Collegiate Institute before he enrolled in the Detroit College of Medicine.

His medical fraternity was Phi Beta Pi.

C. L. Hess, M.D., Bay City

Charles L. Hess, M.D., retired Bay City internist, died February 25 at the age of 80.

He had practiced in Bay City for 31 years before his retirement in 1950. He served on the Bay City Board of Health and the Michigan Department of Health.

Doctor Hess held B.S. and M.S. degrees from the University of Chicago and received his M.D. degree from the Northwestern University medical school in 1914. His internship was done at Cook County Hospital and residency at the Mayo Foundation. During World War I he served with the Chemical Warfare Service and he was chairman of the medical advisory committee of the Bay City Selective Service Board during World War II.

He was a Life Member of the American Society of Clinical Pathology, the American College of Physicians and the American Heart Association, and a member of the American Diabetic Association, the Aero Medical Association, the American Physiological Society and Sigma Xi fraternity.

A past president of the Bay County Medical Society, he was the author of articles in numerous scientific journals.

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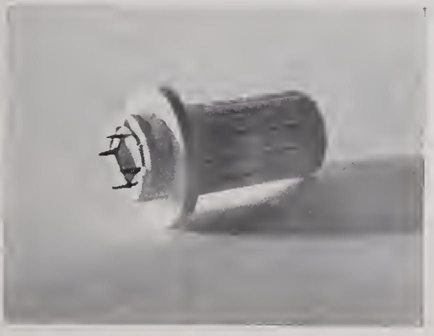

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W. B. Hubbard, M.D., Flint

William B. Hubbard, M.D., Flint othphalmologist, died February 26 near Sebring, Florida. He was 69.

Doctor Hubbard was graduated from the University of Virginia medical school in 1923 and had resided in Flint since 1930. He was affiliated with Hurley, St. Joseph and McLaren hospitals in Flint and was on the courtesy staff of Ford Hospital, Detroit.

He served in World War I and was a USAF Major in World War II. For 20 years he served as an examiner for the Civil Aeronautics Authority.

Doctor Hubbard was the author of a number of research and scientific papers. He was a Life Member of the American College of Surgeons, a member of the American Academy of Ophthalmology and Otolaryngology and a past president of the Saginaw Valley Academy of Ophthalmology and Otolaryngology and the Detroit Academy of Ophthalmology.

Memorial donations were made to the AMA-ERF.

I. S. Lilly, M.D., Stanton

Isaac S. Lilly, M.D., a Montcalm County physician for 52 years and former North American trapshooting champion, died March 5. He was 85.

Doctor Lilly was graduated from the University of Louisville medical school in 1909 and practiced in Lester, West Virginia, until 1915 when he moved to Michigan. After two years in McBride,

Continued on 702

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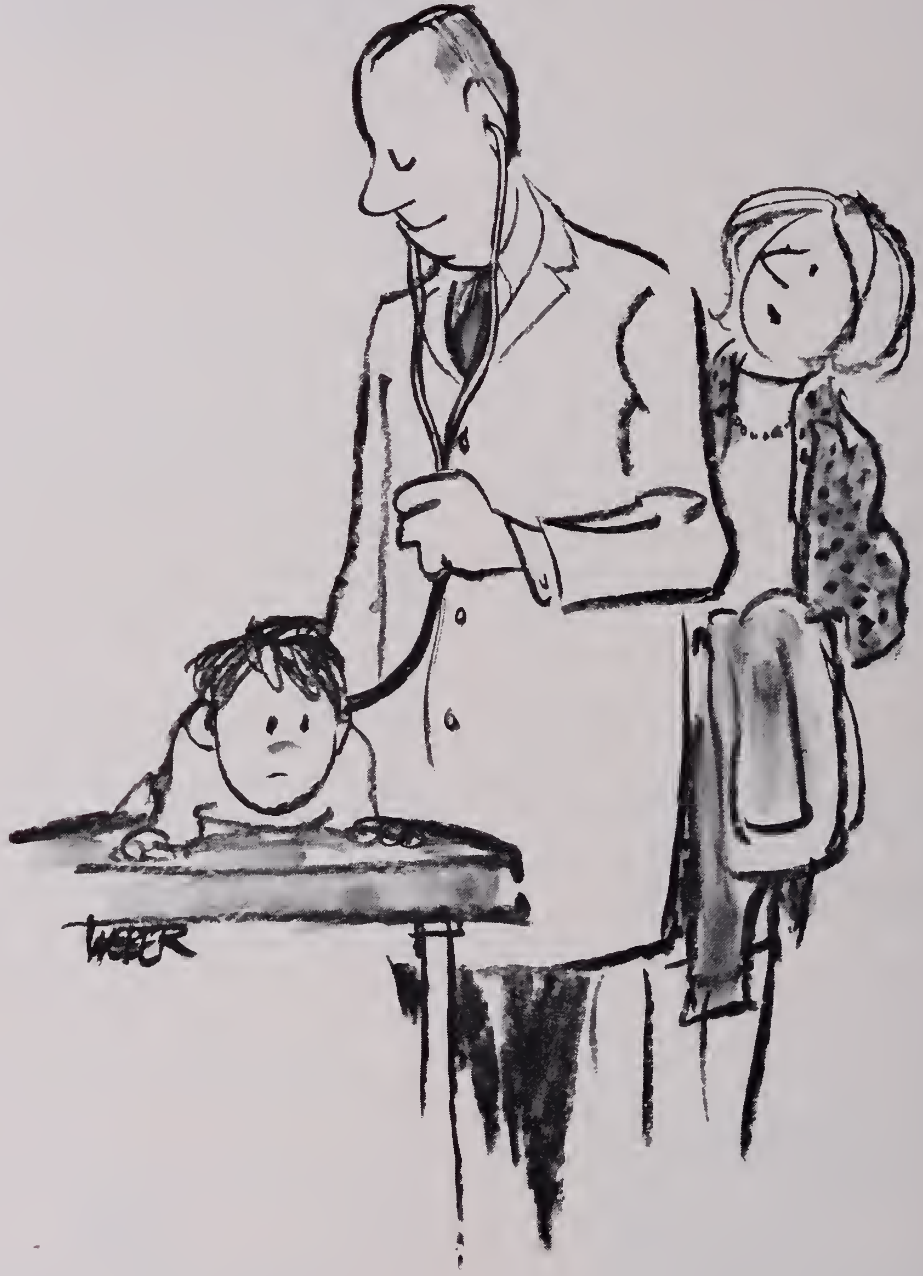

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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he established his practice in Stanton which he continued throughout his life.

He was mayor of Stanton for about 15 years and served as County Coroner for 35 years and health officer for 47 years. A Life Member of the American Trapshooting Association, Doctor Lilly and his son twice won the national father-and-son clay target championships.

He was a Life Member of MSMS and was once president of the Ionia-Montcalm Medical Society.

J. R. McBride, M.D., Lapeer

John R. McBride, M.D., a former president of the Lapeer County Medical Society, died March 28. He was 64.

Doctor McBride was graduated from the University of Iowa Medical School in 1929 and came to Michigan in 1930. He was affiliated with the Lapeer County General Hospital in Lapeer and the McLaren General Hospital in Flint. In addition to serving as president and vice-president he also served as secretary of the Lapeer County Medical Society.

From 1942 to 1945 he served in the medical military service. He was a member of the American Legion and Phi Beta Pi fraternity.

H. C. Wass, M.D., Port Huron

Henry C. Wass, M.D., Port Huron general practitioner, died March 23 at the age of 71. Doctor Wass was a former president of the St. Clair County Medical Society.

Doctor Wass was graduated from the University of Michigan Medical School in 1927. He held a B.S. degree from Michigan State University.

In 1927 and 1928 he served in the medical branch of the U.S. Navy.

He was affiliated with Mercy Hospital in Port Huron and St. Clair Hospital.

R. J. St. Louis, M.D., Detroit

Rene J. St. Louis, M.D., Detroit general practitioner, died March 11 at the age of 80.

He was a city councilman in River Rouge from 1931-1933, was honorary fire chief of the River Rouge fire department, and served as health officer of the River Rouge Health Department.

Doctor St. Louis, who was born in Sandwich, Ontario, received his M.D. degree from the Detroit College of Medicine and Surgery in 1910. He served his internship at Harper Hospital, then entered practice in Midland. After serving in the medical military service during World War I, he began practice in River Rouge.

He was affiliated with Delray Hospital and Wyandotte General Hospital.

Doctor St. Louis was a Life Member of MSMS and a member of Nu Sigma Nu medical fraternity.

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- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
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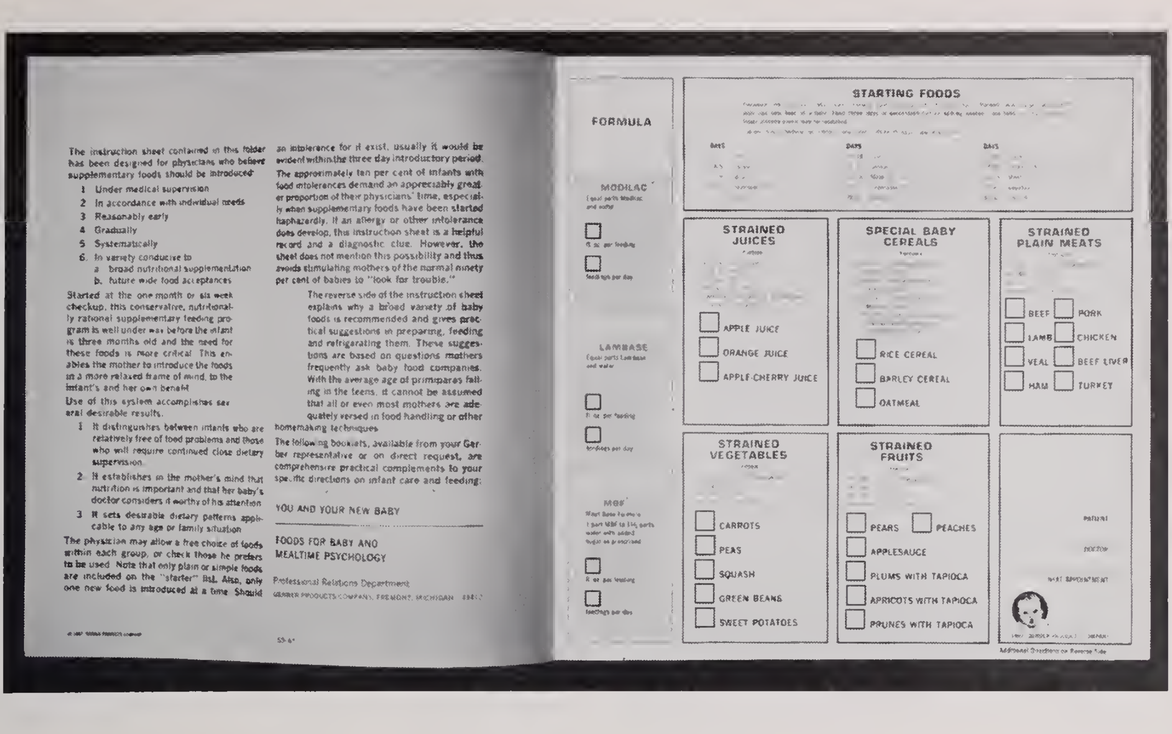

The instruction sheet contained in this folder has been designed for physicians who believe supplementary foods should be introduced

1. Under medical supervision
2. In accordance with individual needs
3. Reasonably early
4. Gradually
5. Systematically
6. In variety conducive to
   a. broad nutritional supplementation
   b. future wide food acceptances

Started at the one month or six week checkup, this conservative, nutritionally rational supplementary feeding program is well under way before the infant is three months old and the need for these foods is more critical. This enables the mother to introduce the foods in a more relaxed frame of mind, to the infant's and her own benefit.

Use of this system accomplishes several desirable results.

1. It distinguishes between infants who are relatively free of food problems and those who will require continued close dietary supervision.
2. It establishes in the mother's mind that nutrition is important and that her baby's doctor considers it worthy of his attention.
3. It sets desirable dietary patterns applicable to any age or family situation.

The physician may allow a free choice of foods within each group, or check those he prefers to be used. Note that only plain or simple foods are included on the "starter" list. Also, only one new food is introduced at a time. Should an intolerance for it exist, usually it would be evident within the three day introductory period.

The approximately ten per cent of infants with food intolerances demand an appreciably greater proportion of their physicians' time, especially when supplementary foods have been started haphazardly. If an allergy or other intolerance does develop, this instruction sheet is a helpful record and a diagnostic clue. However, the sheet does not mention this possibility and thus avoids stimulating mothers of the normal ninety per cent of babies to "look for trouble."

The reverse side of the instruction sheet explains why a broad variety of baby foods is recommended and gives practical suggestions in preparing, feeding and refrigerating them. These suggestions are based on questions mothers frequently ask baby food companies. With the average age of primiparas falling in the teens, it cannot be assumed that all or even most mothers are adequately versed in food handling or other homemaking techniques.

The following booklets, available from your Gerber representative or on direct request, are comprehensive practical complements to your specific directions on infant care and feeding:

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☐ feedings per day

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STARTING FOODS

STRAINED JUICES
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SPECIAL BABY CEREALS
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DOCTOR

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Additional Directions on Reverse Side

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Use it as a checklist
Your √ designates the use of one plain food at a time. Portions are listed and increased gradually until the food is well accepted. Should an intolerance develop, it would be evidenced in the "diary" of food experience. Diagnostic clues would be pinpointed. An alternate food could be selected.

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Start as early as you wish
The system can be started at the initial checkup. Space is provided for you to indicate your choice of formula. Simply enter the amount per feeding and the number of feedings per day in the appropriate square. For normal infants, you may select the Gerber Baby Formula . . . Modilac,™ premodified milk with a near-ideal distribution of calories that has demonstrated superior growth and development.* For newborns where there is a family history of allergy or other reason to avoid milk, MBF™ (Meat Base Formula) or Lambase® can be checked.

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* Lowe, Charles U., M. D. et al., J. Pediatrics 64: 666-682, 1964.

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MSMS Members In the News . . .

Michigan
State
Medical
Society

Marjorie Peebles-Meyers, M.D., Detroit,
has been named one of the "Ten Top Working Women" in Detroit. Each Spring the community salutes ten women for outstanding professional contributions and community service. Doctor Meyers is a Delegate to the MSMS House of Delegates and an Alternate Delegate to the AMA House of Delegates.

John Stirling Meyer, M.D., Birmingham,
will administer a grant of $75,600 from the U.S. Public Health Service to the Wayne State University School of Medicine for continuing the neurology training program. He is professor and chairman of neurology at WSU.

Karl S. Klicka, M.D., Wayne,
Executive Director of the People's Community Hospital Authority, was elected secretary of the new Michigan Association of Hospital Authorities.

Joseph R. Montante, M.D., Orchard Lake,
has been named Republican party organization director in the 19th Congressional District. He is a precinct captain in West Bloomfield Township Republican Party.

Allen B. Moore, M.D., Essexville,
has been appointed by Governor Romney to the eight-member Saginaw Valley College Board of Control. Doctor Moore also was head of the Easter Seal campaign conducted by the Bay County Society for Crippled Children and Adults.

Lionel F. Swan, M.D., Detroit,
president of the National Medical Association, met recently with President Johnson and presidential assistants to explain the role of the newly formed NMA foundation. The foundation's over-all program, aimed toward comprehensive care of the urban poor, includes a nationwide program of recruitment to health professions which offers financial support to deserving young people. The program is being conducted by NMA with the cooperation of the departments of Health, Education and Welfare, and Housing and Urban Development.

Otto K. Engelke, M.D., Ann Arbor,
has been appointed to the AMA Council on Environmental Health and also to the Ad Hoc Committee to Study the Modus Operandi of the Scientific Section.

Geoffrey L. Brinkman, M.D., Detroit,
will direct studies of the aging process that occurs in lungs under a $16,600 grant by tht Michigan Tuberculosis and Respiratory Disease Association to the Department of Pathology at Harper Hospital, Detroit.

William H. Knisely, Ph.D., East Lansing,
has been appointed by the Surgeon-General to the National Advisory Council on Education for Health Professions of the U.S. Public Health Service.

James C. Breneman, M.D., Galesburg,
was presented a 15-year service pin by the local draft board for work as a medical adviser. Also cited was Edmund Talanda, M.D., Kalamazoo, for five years of service to the board.

Albert D. Ruedemann, M.D., Detroit,
professor and chairman of ophthalmology in the Kresge Eye Institute, WSU, will direct the new Children's Fund, established through a $16,059 gift from the estate of Edna F. Selberg. The money will be used to purchase equipment and provide free eye services to children from the Midwest and parts of Canada.

James T. Howell, M.D., Detroit,
executive director of Henry Ford Hospital, has been elected to a three-year term as a hospital representative on the Michigan Blue Cross Board of Trustees.

John Kitchel, M.D., Grand Haven,
representing the Michigan United Conservation Clubs, was chairman of an afternoon session at the conference on "Informed Forces for Environmental Quality" held at Green Bay.

V. K. Volk, M.D., Saginaw,
was honored for more than 30 years as Saginaw County health commissioner in an informal ceremony at which his portrait and a commemorative plaque were placed in the County Health Center. He retired as health officer last year but continues as medical superintendent of Saginaw County Hospital.

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Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

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Governor Names, Senate Confirms So Rice in Charge

R. Gerald Rice, M.D., who had been acting head of the Michigan Department of Public Health since the retirement of Albert E. Heustis, M.D., last October, is now in charge of the department as the director. He recently was named by Governor Romney, and the Senate then confirmed the appointment.

Doctor Rice has been associate director of the department and chief of its bureau of maternal and child health since May, 1966. He previously served two and a half years as director of the Michigan Crippled Children's Commission before that agency became part of the health department under a state government reorganization plan. A naturalized American citizen, Doctor Rice received his medical degree from McGill University in 1940 and earned an advanced degree in public health at Harvard University in 1949.

Before coming to Michigan, he had been with the Pennsylvania Health Department.

SB 1079 Sent to Governor; Should Help Attract MDs

Senate Bill 1079, authorizing the Michigan Board of Basic Science Examiners to waive their test for applicants who have passed a satisfactory set of basic science examinations through the National Board of Medical Examiners, has cleared the legislative process and has been sent to the Governor for signature. The bill, if signed, will take effect immediately.

Waiver of basic science examinations can also be granted to osteopathic or chiropractic applicants for Michigan license, if the Basic Science Board feels that the National Boards of these two groups are equivalent to the Michigan Basic Science examination.

SB 1079 has been supported by the Michigan State Medical Society, the Michigan Department of Licensing and Regulation, the Board of Registration in Medicine, and the osteopathic spokesmen. The bill's passage should at least partially remove the artificial hurdle to physician recruitment created by the basic science examination requirement.

A SECOND LEGISLATIVE proposal to completely repeal the Michigan Basic Science Act, however, has again failed to pass.

A NEW MICHIGAN STATUTE for the purpose of licensing clinical laboratories was moved closer to passage on April 30, when the Senate Health, Social Services and Retirement Committee recommended the measure to the Senate for passage.

HB 2378, drafted with major assistance from the Michigan State Medical Society, survived scrutiny in the two committees of the House of Representatives and was passed by that body in early March. At the time of this publication the bill faces only one remaining hurdle, final Senate approval, before being submitted to the Governor.

HEAVILY SUPPORTED BY MSMS, both Senate Bill 925 and Senate Bill 416 have completed the legislative process and been sent to the Governor. This pair of bills makes possible modernization of the State's school code provisions regarding the teaching of "family living" (sex education). SB 925 was chiefly sponsored by the Michigan Youth Commission, which drew upon medical experts in its deliberations; SB 416 was introduced by Sen. Roger Craig (D-Dearborn) and endorsed as a desirable companion to round out the provisions of the Youth's Commission bill.

Blue Shield Describes Variable Fee Program

BY MICHIGAN BLUE SHIELD

Michigan Blue Shield recently explained details of its new "Michigan Variable Fee" (MVF) programs, designed to broaden existing health care protection benefits for its 4,325,000 members, more than half the population of the State.

The new programs offer "the finest medical-surgical cost protection available anywhere," John C. McCabe, Michigan Blue Shield president, said, "and come as close to the ideal of total financial health coverage as we can within practical realities."

Mr. McCabe said the new programs will, in general:

1. Provide for a more realistic and up-to-date payment method which eliminates present fixed payment schedules which are tied to subscribers' income, with one designed to pay physicians reasonable and customary fees, which traditionally have varied by locality, the nature of the services and the training and experience of the physician. There is no income differential.

O-RAMA
FOR THE UNITED FOUNDATION
UNITED HEALTH ORGANIZATION
H TESTS
HEALTH-O-RAM

Official starter for the Health-O-Rama (co-sponsored by MSMS) held at Northland recently was eight-year-old Denise McDonald, of Madison Heights. Typical of the many who helped through Torch Drive health agencies, Denise was joined by local medical dignitaries, community leaders, and United Foundation representatives at a ribbon-cutting ceremony. The Health Careers Mobile was one of the featured exhibits.

2. Provide new benefits and include others which were previously available only at extra cost under M-75, Blue Shield's previous "standard" protection.

3. Strike out various medical "exclusions" which have been traditional in health care coverage in Blue Shield and commercial carriers. Mr. McCabe indicated that the new MVF programs, while having similar payment mechanisms, will be available in several forms, with different benefit scope to meet differences in group and subscriber needs.

More than 1,700,000 subscribers, most of whom are covered by collective bargaining agreements negotiated between the automotive industry and United Auto Workers Union, negotiated last fall, will receive the new program this October. Drug benefits under the new prescription drug program will be effective in the auto industry in the fall of 1969.

Some 97,000 subscribers, primarily in the steel and rubber industries, have already been enrolled in separately negotiated forms of the variable fee program.

Certain new benefits, however, will be added to all of the new MVF programs. These include unlimited medical care in the hospital in most instances; radiation therapy for benign as well as malignant conditions; unlimited medical consultations in the hospital; more liberal cosmetic surgery and other surgical benefits such as sterilization, when medically necessary, and care by more than one physician in a hospitalized case, when medically necessary.

Benjamin Jeffries, M.D., right, receives from Robert F. Diefenbach, Detroit, newly-elected president of the Michigan Epilepsy Center and Association, a Certicate of Meritorious Community Service. Doctor Jeffries had five years as MEC-A president.

Mr. McCabe said that while many of the contractual limits have been removed from the programs, coverage benefits will only be provided for services which are medically necessary within acceptable standards of medical practice.

Of special significance, Mr. McCabe said, is the fact that, for the first time, benefits for home and office medical care will be provided, on an optional basis, offering a less costly alternate to hospitalization.

McCabe also announced that a prescription drug program, jointly underwritten by Blue Shield and Blue Cross, its sister corporation, is in the final stages of development and will broaden protection "to an even greater extent."

All groups and all holders of individual certificates will receive direct notification of transfer dates as well as specific benefit provisions.

McCabe said that there will be an eventual cost adjustment which will depend upon claims experience and, therefore, no overall estimate of its amount is now possible.

Supreme Court Says Staff Wrong To Cut Privileges

(The following item is from the AMA CITATION publication compiled by the AMA Legal Staff)

The reduction of a physician's staff privileges by the executive committee of a public hospital was invalid, the Michigan Supreme Court ruled. The bylaw under which the committee acted violated due process, because it attempted to confer arbitrary power on the committee with respect to the reduction of staff privileges. The bylaw provided that the committee could reduce a physician's staff privileges if, in its opinion, it appeared that the reduction would be "to the best interest of the hospital and its patients."

The committee notified the physician that it had concluded that his handling of a certain case had been inadequate, inappropriate, and improper, and prohibited him from using narcotic drugs beyond 48 hours without the written approval of the department chief.

The physician's license to practice in the state included the right to practice in public hospitals, the court pointed out. Due process required the committee to act on the basis of reasonable standards in restricting his staff privileges. Since the bylaw contained no requirements as to the physician's knowledge, skill, character or conduct, it attempted to confer on the committee the arbitrary power to reduce privileges according to its whim or caprice, subject only to appeal to the staff and ultimately to the board, whose powers of review were equally arbitrary.

After the physician filed this suit, the list of staff appointments for the following year was announced. The physician was not reappointed. The trial court denied his motion to amend his complaint so as to raise the issue of the validity of the failure to reappoint him. That issue remains to be disposed of.—*Milford* v. *People's Community Hospital Authority*, 155 N.W.2d 835 (Mich., Feb. 9, 1968)

The decision of the intermediate appellate court was reported in THE CITATION, Vol. 14, No. 3, p. 42.

HARMON

TREMAIN

Harmon to Join MDPH; Cross Names Tremain

Effective June 1, Edwin L. Harmon, M.D., will retire as Michigan Blue Cross medical director and join the Michigan Department of Public Health as consultant to the Bureau of Medical Services.

R. Gerald Rice, M.D., Director of the Department of Public Health declares, "We're fortunate this nationally-renowned health care expert is available to us as a consultant. Doctor Harmon is remarkably equipped to help delineate the standards for services in hospitals."

Harold L. Tremain, M.D., assistant medical director at Michigan Hospital Service, will be promoted to fill the Blue Cross vacancy. His assistant will be M. J. Armstrong, M.D., Birmingham, who joined Blue Cross in April.

U-M NAMES LAPIDES TO HEAD UROLOGY

Jack Lapides, M.D., professor of surgery, has been appointed head of the section of urology in the Department of Surgery, University of Michigan Medical School.

Doctor Lapides was graduated from the U-M Medical School in 1941 and stayed for his internship and residency. He has been a member of the faculty since 1948.

Appoint Moses New Editor

John W. Moses, M.D., Detroit, began duties May 1 as the new Scientific Editor of *Michigan Medicine.*

He was elected by The MSMS Council at its April meeting, upon the recommendation of the Publication Committee, to fill the vacancy created by the resignation of George H. Lowrey, M.D., of Ann Arbor.

Doctor Moses, who is director of medical education of Mt. Carmel Hospital, is active in the Wayne County Medical Society and is a delegate to the MSMS House of Delegates.

The Council praised Doctor Lowrey for his fine service. He became Scientific Editor in April, 1966.

(Further details will appear in the June issue.)

Health Congress Soon in U.P.

The Third Annual Upper Michigan Health Congress will be held at Houghton, May 22-23, sponsored by the Michigan Health Council, Technological University, Michigan State Medical Society, Michigan Foundation for Medical and Health Education, and nearly 100 other member organizations of the Council.

A highlight will be the Michigan Week banquet at Michigan Tech, May 22 with Win Schuler, Marshall, General Chairman of the 1968 Michigan Week, as banquet chairman; Hugh W. Brenneman, MSMS Executive Director, as toastmaster; and Bennett J. McCarthy, Vice-President of Michigan Hospital Service, as speaker. The Michigan Blue Cross-Blue Shield will sponsor the banquet, featuring coho salmon.

"All science begins and ends with medicine" is the line in a Health Careers Mobile exhibit that holds the attention of two Detroit teenagers. The poster is part of the University of Michigan Medical School exhibit. The Health Careers Mobile has been at the Detroit inner-city high schools and now is looping around the state, under the active sponsorship of the Michigan Health Council and MSMS, to interest young people in possible Careers in the Medical field.

ADD: IN MEMORIAM

In addition to the names reported in the May "In Memoriam" the following news has reached the MSMS office. Details will follow in the June *Michigan Medicine*:

Van D. Barnes, M.D., Livonia, died April 7.

John R. McBride, M.D., Lapeer, died March 28.

ON AMA PROGRAM

Paul W. Gikas, M.D., and Melvin Selzer, M.D., both of Ann Arbor, will speak at an AMA session on Auto Accident Injuries during the 117th Annual Convention June 16-20 in San Francisco.

Wayne Installs Danforth; Fryfogle President-Elect

"I hereby pledge to wear its mantle with dignity and dedicate myself to support traditional ideals flexibly enough to progress wisely, to strive for unity of thought and purpose, to provide sanctuary of counsel to all in need, and to perpetuate the image of trust to the community we serve," said James C. Danforth, Jr., M.D., upon taking office as president of the Wayne County Medical Society during its annual meeting May 6.

Michigan Medicine will carry the full text of Doctor Danforth's inaugural address in a future issue.

James D. Fryfogle, M.D., was announced as president-elect during the meeting.

George L. Reno, M.D., took over as the new secretary.

Immediate Past President Frank B. Bicknell, M.D., was elected to a five-year term as trustee, and Brock E. Brush, M.D., and Ralph R. Cooper, M.D., were re-elected as trustees.

There will be several new faces on the Council of WCMS during the coming year. Louis R. Zako, M.D., was elected as secretary to the General Practice Section; Donald I. Bryan, M.D., new secretary to the Medical Section; and Raymond J. Barrett, M.D., new secretary of the Surgical Section. Returning to the Council are Leon Rottenberg, M.D., (chairman, General Practice Section), Fred W. Whitehouse, M.D., (chairman, Medical Section), and William J. Yott, M.D., (chairman, Surgical Section).

Other new members of the Council are Clayton M. Shors, M.D., Gerald H. Mandell, M.D., Frederick Weissman, M.D., and Richard L. Lamont, M.D., all of whom are serving as Geographical Representatives.

FOUR MD GRADS HONORED BY WSU

Four WSU alumni received the coveted Distinguished Service Citations at the WSU School of Medicine Reunion May 15. They are all professors and chairmen of departments of their respective medical schools, They are Fred Harbert, M.D., otolaryngology, Jefferson Medical College; Jules H. Masserman, M.D., psychiatry, Northwestern University School of Medicine; Edwin T. Nishimuru, M.D., pathology, University of Hawaii School of Medicine; and Peter J. Talso, M.D., medicine, Loyola-Stritch School of Medicine.

These physicians were honored for "distinguishing themselves, their school and their university."

A special Centennial Award was presented to Duncan J. McColl, M.D., of Port Huron, who was born near Glachan, Ontario, November 24, 1868, the year of the University's founding. Doctor McColl entered the Detroit College of Medicine, a forerunner to the School of Medicine, in 1889 and graduated in 1893.

(More details will appear in future issues of *Michigan Medicine*.)

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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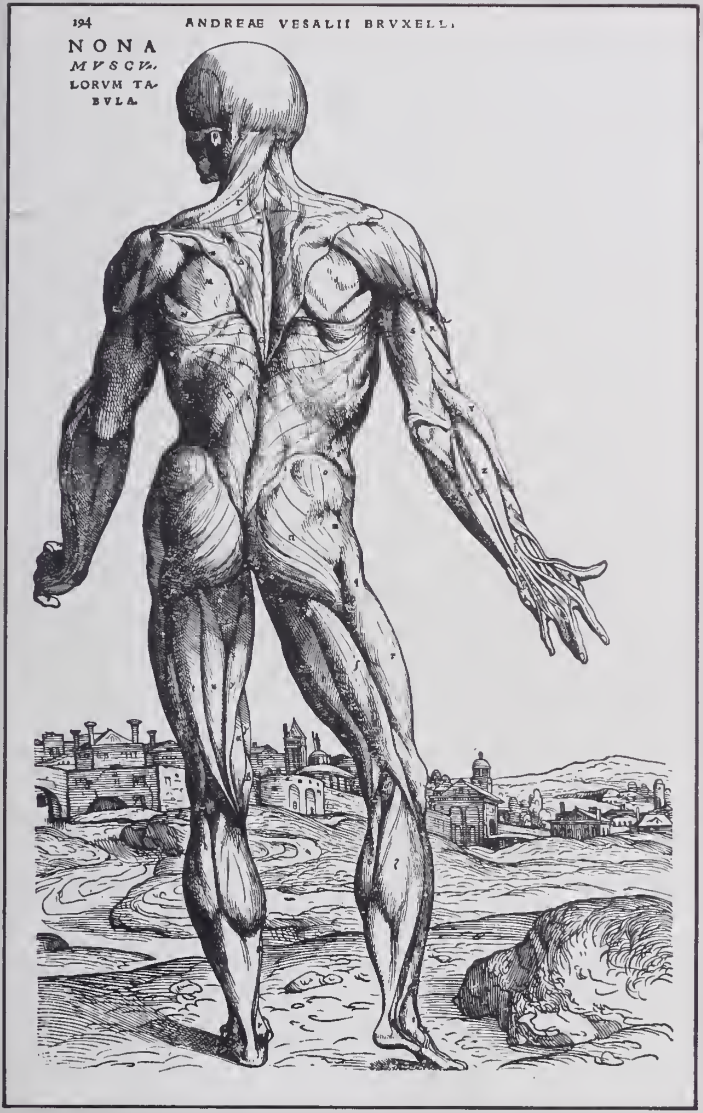

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This woodcut of muscles, attributed to the workshop of Titian (Italian, 1477-1576) will be one of the more than 130 original works of art in the "Ars Medica" exhibition at The Detroit Institute of Arts during the 1968 MSMS Annual Session in Detroit in September. See page 739.

MICHIGAN STATE MEDICAL
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AMONG THE IMPORTANT ARTICLES

The New Physician
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References:

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ABOUT THE COVER:

The woodcut on the cover is one of the original works of art that will comprise the "Ars Medica" exhibition at the Detroit Institute of Arts during the 1968 MSMS Annual Session. See the article on Page 739.

The sketch on Page 732 with the Llinas article was drawn by Craig Dennis, a senior at Lansing Eastern High School who plans to attend college to study medical illustrating.

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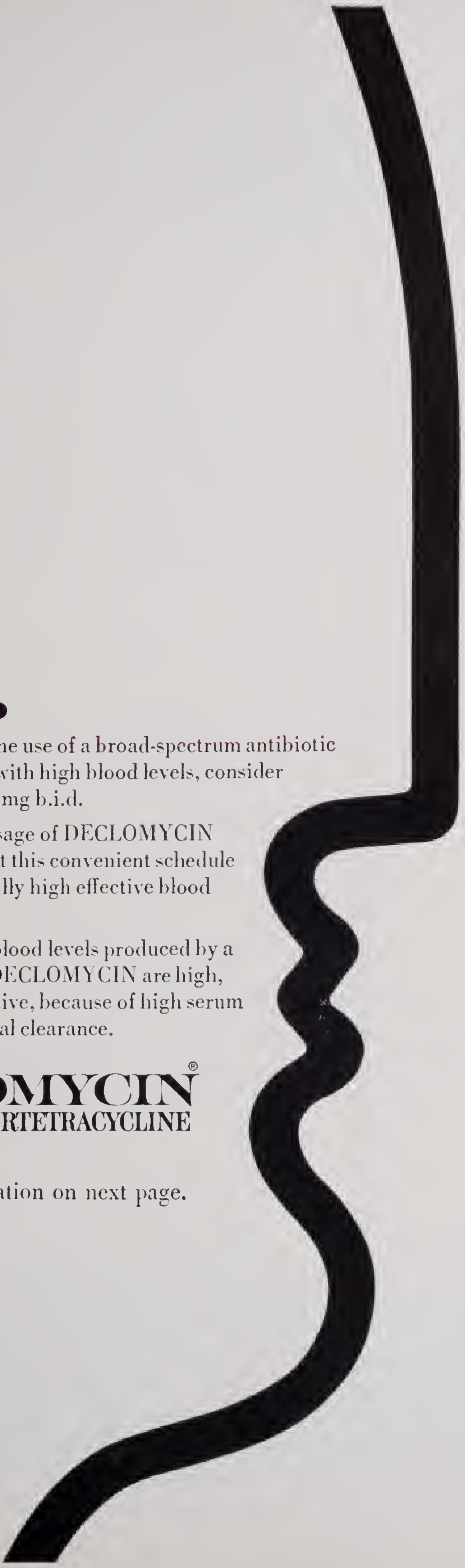

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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

About Our Image . . .

How important is image?

Image is important it seems to me if doctors are really concerned about the opinions of their patients, about the comments of editors and educators, and about the attitudes voiced by legislators and other professionals.

Image is important as doctors perform well, obtain respect, and achieve economic security and self fulfillment.

* * *

You might ask, "what do you mean by image?"

There is a simple definition: Image is a mental-emotional picture held by our many publics in health, government, education, communications, etc.

These impressions of doctors are gained every day, every hour in so many ways.

* * *

Can the image be changed?

Certainly. And the impressions are changed almost every hour for the better . . . or the worse.

May I be so bold as to write about some of the factors that effect your image — so you might be able to evaluate your weak points and build upon your strengths?

Our image, I believe, relates to . . .

A man's knowledge, his professional abilities, his management skills, his ability to budget his time;

A person's appearance, voice, handshake, eyes, smile;

A doctor's civic contributions, business practices, family relationships;

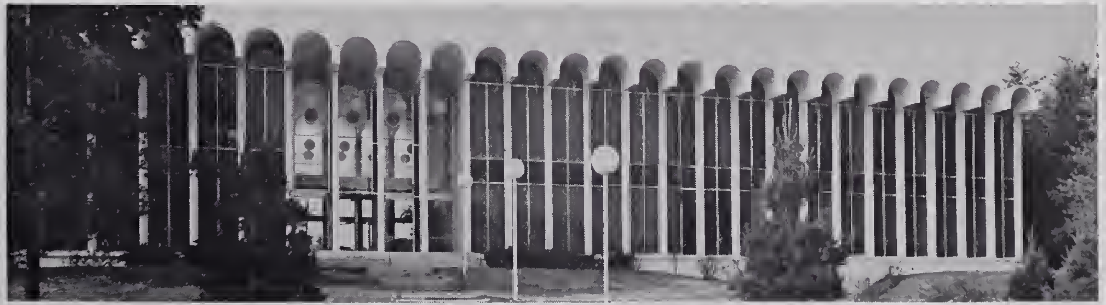
A physician's patience, tact, manners, cordiality;

A person's dedication to continuing education, to ethics, to his nation.

These comments have been aimed at every physician as an individual. I firmly believe that each of us can improve our personal image if we continue to improve our professional performance, if we fulfill our role as a citizen, and if we respect the members of our family.

* * *

As a former chairman of the MSMS Publication Committee, I would like personally to thank George H. Lowrey, M.D., for his outstanding service as Scientific Editor of Michigan Medicine since April, 1966. And at the same time, I wish John W. Moses, M.D., the new Scientific Editor, the best as he succeeds Doctor Lowrey. MSMS indeed has been fortunate to have such men in recent years as Wilfred Haughey, M.D., C. J. Tupper, M.D., George H. Lowrey, M.D., and now John W. Moses, M.D., as dedicated editors to provide the members with the best of timely, vital scientific articles.



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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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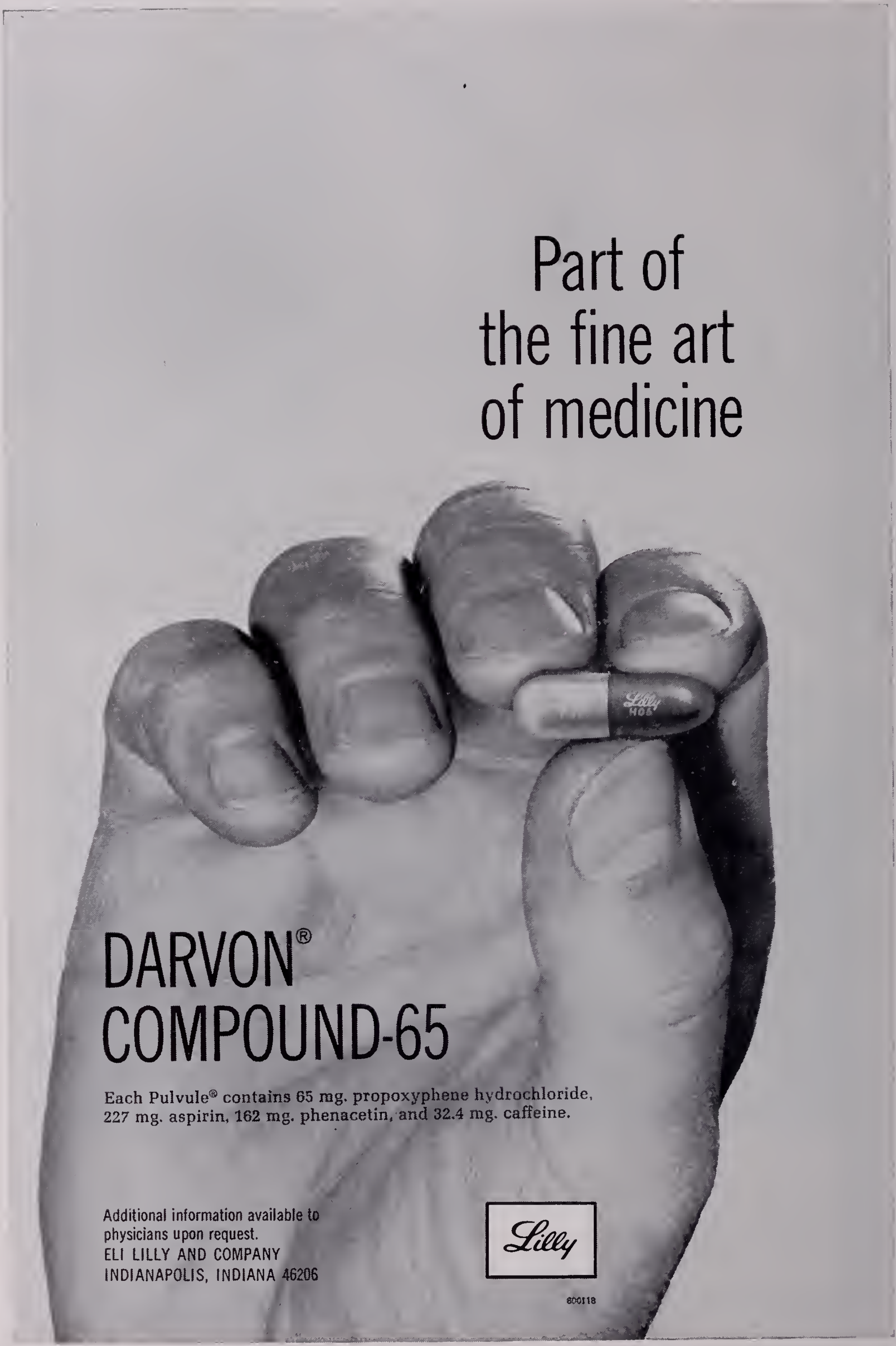

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Obstructions and Pitfalls In Implementing the "New Physician"

BY RICHARD M. MAGRAW, M.D.
WASHINGTON, D.C.

The word "pitfall" implies a hidden and not easily recognized danger or difficulty when, in fact, there are plenty of obvious and recognizable obstructions which block our way and impede our progress toward "the new physician." Moreover the term "pitfall" suggests an unforeseen interruption in a program already underway, implying that we are farther along in this effort than we are.

In this project we are still struggling with obvious blocks to attain the goal. To draw an analogy from a childrens' Christmas story, "The Little Engine That Could," we are yet on the uphill track of "I think I can, I think I can" rather than having attained the downhill version of "I thought I could, I thought I could."

This distinction is made to emphasize what has been and continues to be the chief block to the implementation of the new physician concept, namely, our confusion as a profession about realities of our time. In part, because we have been too busy practicing and providing care, we have not understood the enormous changes in our time, and we have consistently underestimated the complexity of the adaptations which are demanded of us. We are indeed "walking backward into the future."

For example, there has been a general assumption that the task of implementing the new physician could be accomplished simply by persuading the medical schools and teaching hospitals to develop an appropriate instructional program for family practices. However, to implement the new physician, not only must medical education (undergraduate and graduate) be restructured, but the division of labor within the traditional medical profession must be revised; the relationship and functions of the elements of the larger medical care apparatus (i.e., clinics, hospitals, and related health personnel) must be modified; arrangements for payment for medical services will need to be significantly altered; and public understanding and acceptance must be won. In each of these areas there are obstructions and pitfalls.

I. Blocks to the Development of Residency Programs within Medical Education

A. Blocks within the medical school and its associated hospitals and clinics.

Although most schools are currently modifying some of the undergraduate curricula, we will not here consider undergraduate aspects of education for this new role. The modification of undergraduate education is not absolutely essential to implementing the new physician concept.

Since most physicians have heard much about the pitfalls and obstructions of implementing this program within the medical schools, I will list them here only in an abbreviated way.

WHEN FACULTIES COME to consider establishing programs for the "new physician" in medical schools, they find they have undertaken a very large order for these reasons:

(1) In general, medical school faculty members are not knowledgeable about the medical care apparatus per se and are unaccustomed to assessing the characteristics of the practicing profession in terms of the medical needs of society. They are often so far removed from the communities' medical care needs as to be unable to make judgments regarding the training required for primary care in today's world.

(2) Medical schools, hospitals, or clinics are usually referral or charity institutions or both. As such, they have neither an established role in, nor a tradition of providing first-line comprehensive medical care. And, as they attempt to develop new and more suitable facilities for training, they expect objections from the practicing profession for intruding into primary care. Thus far, their anticipations have proven correct.

(3) There is a new division of labor implicit in the concept of the new primary physician which runs counter to the existing departmental structure as well as the associated professional

models which are strongly entrenched in medical school usages, concepts, and politics.

(4) The campaign for the new physician developed in relation to implied or expressed threats to the research enterprise, which is the preponderant force in today's medical school.

(5) The traditional medical school has evolved into a medical research and graduate training center. The medical education part of this enterprise (as opposed to the research portion) is not able to undertake a new training program without major additional financial support.

(6) It is very nearly impossible for any one school by itself to undertake the required major revision of either graduate or undergraduate training. Hence, a cooperative effort is necessary. Further, it is difficult for medical educators, even as a group, to undertake to produce a "new physician," (including a new role) unless the institutions and arrangements of medicine and society are also changing to provide a place for him.

In addition to lacking the incentive to implement this program, academic medicine has a conservatism of its own, which, in this matter, appears to be about as intransigent as that of the practicing profession.

B. Obstructions within the teaching hospitals (public or private) not affiliated with medical schools.

At the present time some of the most promising starts toward implementing the new physician are occurring in these hospitals, particularly the private ones.

City and county hospitals (charity hospitals) are having difficulty with the concept. Their major problem appears to be that the medical care provided the patients by such hospital staffs has been far from comprehensive. Regardless of the quality of in-hospital care given, the overall care usually has been fragmentary because of the hospital ward and categorical orientation situations. Outpatient care has been poor in quality, and concepts of community health needs have been limited to calculating bed capacity and comparing the technological sophistication of the particular hospital with similar institutions.

Private hospitals are in a stronger position, for implementing the training for the new position, for doctors on their staffs provide primary care, paradoxically, because their work is oriented much more toward their offices and the community than to the institution. However, the private hospital, to a greater or lesser extent, has a recognized position of trusteeship for the medical resources of the community, thanks to Hill-Burton regional hospital planning, etc.

THE MOST ESSENTIAL new elements for education of the personal physician are the demonstration of: (1) the managerial responsibility of the individual personal physician, and (2) the linkage between such responsibility and the cooperative enterprises of medicine as in the hospital and its medical staff. At present the private hospital-medical staff combination offers the only existing demonstration of this, although the models are far from being adequate for instruction of tomorrow's physician.

II. Blocks within the Practicing Profession

The obstructions within the practicing profession are not fully separable from those within the medical schools and teaching hospitals. They all derive from a tendency among some doctors to see this as a circumscribed issue involving, fundamentally, the general practitioners. This is opposed to seeing the issue as a general restructuring and rationalization of medical care or as understanding the need for such restructuring.

Now the chief overt opposition to this concept comes from some groups of internists and pediatricians and, to a considerably lesser extent, from obstetricians and general surgeons. Not surprisingly, the publications of the Millis and Willard reports, as well as the other reports and publications which have supported the concept, have resulted in a crystallization of opposition to the "new primary physician" concept within the groups who feel threatened.

PEDIATRICIANS AND INTERNISTS have objected to this concept because they sensed in it a contrived revival of the surgically oriented and, in their view, inadequately trained general practitioner and have perhaps felt it an implied criticism or undermining of their role.

In general they have perceived this as a threat, rather than an opportunity for evaluation of their own role. Editorials in some journals this past year, while acknowledging that there are now different kinds of internists and pediatricians which may require different training, tend to see these as variations within the disciplines of pediatrics and internal medicine rather than as a small-scale replica of the generalist-specialist problem.

As yet internists and pediatricians seem little aware that in the long run not only the interests of the American public, but the self-interest of all personal or family physicians, regardless of professional label or type of training, will be best served by defining this function and improving it by training. At the bottom of this problem are two cherished misconceptions: First, internists and pediatricians are retaining an outdated concept of their role and training as general specialists. It is becoming clear to all that these general specialists have already been divided by their work into two broad groups—those that preponderantly provide primary care and those that serve as consultants. It is, further, becoming clear that the evolving organization of medical care demands further polarization of these roles and a formalization of them.

Second—another cherished idea is that the internist or pediatrician should be trained for the consultant aspect of his work, but he needs no special training for primary care. This idea is apparent in the insistence that all internists are internists and all pediatricians are pediatricians; that is, they should all have a common training and pass a common board examination demonstrating a consultant's level of competence.

A CYNIC MIGHT remark that this incidentally assures their maintaining amateur standing in the field of primary care.

Romano, some time ago, stated that the scientist's first loyalty was to his clinical material. The "clinical material" of the internist trained on the wards of a teaching hospital is very different from that involved in the patient care he will provide as a primary physician. He has not yet resolved the issue as to what "clinical material" he will give his loyalty.

Not the least of the problems of implementing of the new physician concept within the medical profession itself is the political power and vested interest of existing specialty boards. These boards have performed valuable functions for society by elevating professional standards. However, their orientation in medical care has always been limited to the specialty. They have eschewed any assessment of overall medical care or unmet community needs. Each specialty board has concerned itself with improved professional functions in the specialty, usually by making progressively more demanding measurements of expertise.

Taken together these forces within the medical profession seriously impede development of educational programs and recruitment for the new professional model.

III. Blocks in the larger apparatus of medical care and health; e.g., clinics, the hospitals, and related health professions

As noted earlier some of the most promising beginnings in graduate training programs for the new physician are being made in private hospi-

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tals. There are, however, some important pitfalls involved.

IN WHAT MIGHT BE described as the "hospital view of medical care," the hospital rather than the primary physician is seen as the center of medical care. This is apparent in the recommendations made by various governmental and quasi-public commissions concerned with meeting the medical needs of society. They recommend that hospitals* should serve as the center of care for all patients and that they should specifically manage the personal medical care and provide referral services for all persons who do not have personal physicians.

Owing to the seriousness of the need, the shortage of physicians, and the lack of either a consensus in, or a forward looking alternative from, the medical profession, this hospital-center idea has considerable appeal. This idea is also widespread among hospital administrators and planners in medical care. It is one of the obstructions of implementing the new physician since it implicitly denies the need for his function. It suggests that we do not really need any professionally trained person to carry out this function, at least for the persons who have now been given medical purchasing power but do not have personal doctors. It becomes all the more important when we understand the weight which this view is likely to receive politically and recognize that hospitals heretofore have characteristically looked inward and oriented themselves to a concept of care of episodic disease rather than comprehensive continuing care. Thus, in many ways the hospital portion of medical care is conceptually the natural antitheses to the part of comprehensive personal care which is the basic function of the new physician.

IV. Blocks in medical economics and the payment for medical care

In my view the most important obstructions to implementing the new physician concept are in the economics of medical care and specifically in remuneration for services. Although the history of this is long and complicated, the problem itself can be simply stated. Comprehensive personal medical care has seldom been explicitly recompensed. In general it's been a "loss leader" or a "give away item" at the medical market place. Schedules of benefits of third parties are endlessly detailed and explicit in regard to technical procedures. Only vaguely and implicitly, if at all, however, do these schedules acknowledge that there is a wider element of skill and time required for comprehensive care of the patient than for obvious procedures of medicine. There is probably nothing which could be done in medical training or in the organization of medical care which would as quickly implement the concept of the new physician and correspondingly rationalize our entire system of medical care as developing a realistic remuneration for the managerial and integrating services of the primary physician. It is hard to do this on a fee basis. How can he be paid for studying the consultation report or for all the other things involved in integrating a patient's care or preventive maintenance?

IN MY OPINION there is no more practical way of doing this than establishing, in addition to existing fees for service, some modest "retainer

AMA Ad Hoc Report On "New Physician" Available from MSMS

Thoughts about "the new physician" were advanced in the Report of the AMA Ad Hoc Committee on "Education for Family Practice," published by the AMA. William R. Willard, M.D., vice-president and dean of the University of Kentucky Medical School and chairman of the Ad Hoc Committee, spoke at the 1967 MSMS Annual Session and was followed by Doctor Magraw. The Report was studied in detail this past year by the MSMS Education Liaison Committee. Interested MSMS members may obtain a copy of the Ad Hoc Committee report by writing to MSMS, 120 West Saginaw, East Lansing 48823.

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*In order to avoid false issues it is important to understand that many people use the term "hospital" here in a broadly encompassing way meaning the medical care apparatus of society with the physician at its core. "Medical center" or "health center" would probably be a preferable term, but the idea of hospital has both high visibility and loyal constituency.

fee" or "availability fee" paid annually by each patient (or on his behalf by a third party carrier) to the doctor who assumes ongoing medical responsibility for him.

Devising some way of realistically paying for comprehensive personal care would probably brush away all existing obstacles in the path of the implementation of the primary physician. It would define, in the public mind, the professional role which has become all but invisible under current medical care and medical pay arrangements. It would, similarly, define in professional thinking the function which some doctors still regard as an attempt to give to "airy nothing a local habitation and a name." Payment gives it substance. In this regard it's well to recall the bitter struggles which occurred within the last few years over the issue of surgical privileges in hospitals for general practitioners. These struggles were not wholly or even primarily economic. They grew out of the general practitioner's difficulty in defining a professional role for himself or maintaining a professional identity in other terms than surgical expertise. Surgery was what he got paid for, and it was correspondingly in surgical terms that he defined his function and measured his professional identity.

The personal physician's situation regarding pay for comprehensive personal care is analagous to that of the free lunch in the days of the saloon when the lunch was supplied to help sell the beer which made the profit. By analogy, the beer is the technical part of medicine that third parties pay for. When the beer was separated from free lunch (that is the surgery was separated from the comprehensive personal care), not only was the doctor's livelihood affected, his professional identity was diluted and threatened.

V. Blocks in public understanding and acceptance

Perhaps the biggest block to public understanding and acceptance of the new physician is a psychological one wherein the individual members of society, particularly at a time when they are not sick or active patients, maintain the fiction that illness or disease is an alien external thing which can be dealt with, removed, or cast off without involving them personally.

The potential dependence on another person, the lessened interpersonal distance, and the trust required all are a little frightening and will be avoided like "flouridation" unless their usefulness is understood.

At present the implementation of the primary physician may still be largely in professional hands, but soon and in any event, ultimately this will be a social or political decision. This professional role concerns all doctors, not only general practitioners, internists, and pediatricians, as it will bring to pass a long overdue and adaptive division of labor.

SUCCESSFUL IMPLEMENTATION of this new physician is of importance to all Americans as it will provide integration at the interface between the individual patient and an increasingly complex technology and apparatus of medicine.

Failure to bring this about is almost certain to cost us part of what we value the most, the human content of our lives.

Clinical Response to Iron-Polysaccharide Complex In Geriatric Patients With Iron-Deficiency Anemia

ABSTRACT — The geriatric patient often offers so many problems that iron-deficiency anemia is frequently neither suspected nor investigated. This article indicates that simple therapy with an oral preparation results in a prompt response in most older patients.

BY JACK F. SANDERS, M.D.

ALMA

Physicians have been offered many types of iron preparations, including ferrous sulfate, gluconate, and fumarate. Although they produce the desired hemoglobin responses, these forms of iron have been reported to irritate the gastrointestinal tract.[1,2,4] Adverse effects accompanying the administration of these agents (e.g., nausea, diarrhea, anorexia, constipation, abdominal cramps) are sufficient in some cases to interrupt their use.

When iron in the form of a polysaccharide complex was found to be less toxic to mice than the standard ionized forms, its possible clinical applications were investigated. In this form, the elemental iron is supposedly bound in complex until dissociated by hydrochloric acid in the stomach; it is absorbed in the duodenum and jejunum, where iron absorption is maximal. Children receiving non-ionizable iron have been reported to respond well, with good hemoglobin response time, and no clinically significant adverse affects. In geriatric patients whose chronic diseases may render them less responsive and more sensitive to irritating therapeutics, such a non-toxic form of iron would be desirable.

To further test the acceptability of this water-soluble hematinic,* the present study was conducted in geriatric patients with iron deficiency anemia.

Method and Material

Participants in this study were selected from residents of the Michigan Masonic Home and Hospital, a uniform socio-economic group with a mean age of 84. Of 392 screened with CBC's with peripheral smears and stools for blood, only 20 had iron deficiency anemia requiring treatment (i.e. hemoglobins below 12.0 grams, average 10.7 grams, and hypochromic morphology). They ranged in age from 78 to 95. Diagnostic upper GI and colon examinations were also performed in 80 of the possible candidates. Of these, 3 were found to have colon malignancies and were successfully operated before signs or symptoms had become manifest; they were not included in the study. Carcinoma of the caecum was discovered in 1 patient and successfully operated after the initiation of iron therapy. Eight patients showed trace to + blood in the stool without identifiable source. Multiple chronic diseases which might interfere with the response were present in every patient. Cardiovascular renal diseases complicated the conditions of 16 patients; 4 men had prostatism; 2 women chronic glomerulonephritis.

Patients ate a 1.0 Gram salt diet at special diet tables. The stable living pattern was interrupted in only 1 patient who was removed to another hospital for surgery.

Each patient received polysaccharide iron complex in elixir form, one teaspoonful bid for a total daily dose of 200 milligrams of elemental iron. Nurses administered all medications. Subjective evaluations of the palatability and acceptability of the elixir were offered by the patients.

Prior to therapy, CBC's including reticulocyte counts, hemoglobin and hematocrit values, BUN's, urinalyses, and Diagnex Blue tests were done. Because the time for response to iron therapy in geriatric patients was not known, treatment was continued for 12 weeks and repeated testing was done at 2 week intervals during treatment and at 1 month and 6 months after its termination. One technologist performed all the tests.

Results and Discussion

During the first 28 days hemoglobin values rose in 15 of 19* patients with an average increase of 1.5 grams, and with corresponding hematocrit increases of 2.33 vols.%. The 5 non-responders all had severe cardiovascular renal disease and chronic blood loss in the stool. Only 1 of the responders had blood in the stool. Two of the responders had no free gastric hydrochloric acid and 9 had only a

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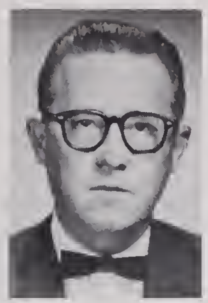
*Niferex, oral iron polysaccharide complex marketed by Central Pharmacal, Seymour, Indiana.

*1 of the 20 patients died of unassociated causes too early in this study to be included.



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trace as indicated by the Diagnex Blue test. Reticulocyte counts showed no apparent relationship to response or lack of it.

Six months after the 12 weeks of administration of iron polysaccharide complex, 4 of the 15 responders had dropped back to their original hemoglobin levels, with no evidence of blood loss. The 4 non-responders were all lower at the end of the study than initially despite the iron intake.

One patient complained that he "just didn't like" the medication. One complained of momentary flushing and another of transistory stomach distress for a few minutes after each dose; the complaint was not serious enough in either to require alternation of therapy. All patients wore dentures; there were no denture stains.

Conclusion

Simple iron deficiency anemia in a geriatric population on a well controlled pablum is less prevalent than commonly supposed, only about 1 in 20. Non-ionizable polysaccharide iron was effective in 15 of 19 such patients, and was well accepted and well tolerated in all 19. An arbitrary dosage of 200 milligrams of elemental iron per day produced clinical responses within the first 28 days of therapy. None of the patients had any significant gastrointestinal irritation or any sign of toxicity. The coexistence of multiple chronic diseases did not interfere with response, with the exception of cardiovascular renal disease with elevated BUN's and chronic blood loss. Total absence of free gastric hydrochloric acid or only trace amounts as indicated by Diagnex Blue testing did not interfere with iron absorption and hemoglobin response.

These preliminary studies warrant further investigation in depth and with controls of this type of iron therapy.

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Early Strategies in the Treatment Of the Anxious Patient

ABSTRACT—Anxiety is a "fear syndrome," expressing a patient's reaction to a life situation which he perceives as dangerous. When the physician gains some insight into the nature of the patient's fear, and communicates this understanding to him, within the framework of a friendly doctor-patient relationship, the condition is apt to improve.

BY JOSE' J. LLINAS, M.D.
LANSING

All of us have lived through times of anxiety and tension. Moments of dreadful anguish, torturing expectations that something terrible is about to happen, and that we are powerless to prevent it, are a universal experience.

Anxiety becomes of concern to the physician, however, only when it is so constant or so severe that it interferes with the patient's enjoyment of life, his relationship to others or his ability to work.

Definition

Anxiety is a disagreeable, unpleasant feeling, which patients describe in a variety of ways, since it has both subjective and objective physiological components. They are "nervous," "apprehensive," "worried," "insecure," "shook-up." They have misgivings about their state of health, and the soundness of their minds. They complain of head pressure, pain in the chest, palpitation, nausea, chills, fever, cold hands, sweating, agitation, restlessness, insomnia. . . .

They are scared, and show the signs and symptoms of fear; though they can't exactly tell what terrifies them.

There is a wide spectrum of clinical pictures, from the mildly apprehensive patient who worries a little more than he should, to the one in an acute panic reaction, who is convinced there is something terribly wrong with him.

Understanding Anxiety

A syndrome so common and ever present, must fulfill a definite role in human affairs. There are a number of explanatory theories, of which the psychoanalytic one is the most comprehensive.[1,2,3,4]

Like fear, to which it is related, anxiety seems to have a protective function. Just as fear helps with physical survival, anxiety helps in the world of interpersonal relations towards what we may describe as *emotional survival*: the ability to gain acceptance from others.

Reaction to Danger

Like fear, anxiety is a primary reaction to danger. Fear refers usually to a danger without, clearly visible to others; anxiety refers to an internal danger. Like the Trojan Horse, the anxiety attack is an assault from within.

Conflict of Emotions

Internal danger means of course, that there is strife within the person.

As a human being grows and develops, he has to acquire not only control of external circumstances, but also mastery of himself.

Most of the problems the child faces can be reduced to ways and means of integrating his own self-centered needs with those of his environment. There is always conflict between the child's egoistic love of himself, and his more altruistic love of others. It is only because the child wants the support and affection of his parents more than he desires his constant comfort, that he is able to divest himself of some of his more self-centered strivings.

Of the two forces the parents use for educating the child, love is, of course, the most important; but fear always plays a fundamental part. Both are involved in creating unendurable distress if the child does not respond by making progress along his developmental path. As one looks back, superseded and forgotten conflicts are strewn along the way, as so many discarded old cocoons.

In the process, several types of fear can be distinguished, from the earlier and more primitive, to the older and more socially sophisticated:

(1) fear of losing the parent, and parental physical care ("dependency")

(2) fear of losing the parent's love

(3) fear of being punished for one's fantasies

of an aggressive or erotic nature, involving the parents (the punishment imagined as some sort of retaliatory deprivation or damage)

(4) fear of losing self-esteem (self and social approval)

These anxieties go from a highly *personal* concern about physical bodily needs to a highly *interpersonal* fear of disapproval.

Has a mature human being overcome all of these fears? The normal person when undergoing stress, and the anxious patient all the time, they both manifest a good many facets of these developmental anxieties.

A Clinical Example

A demonstrative vignette may help make our discussion more meaningful at this point.

A 40-year-old woman, a clerical employee at the admitting office of a small hospital, was referred for psychiatric evaluation because of constant fears of a heart attack. She had been admitted to the hospital on several occasions with complaints of palpitations, intense fear, restlessness and mild chest pain.

When reassured by the doctor's examination that there was no apparent organic disease, she would calm down some, but continued to worry. Her fear then was that there might be something wrong with her which the doctor was not as yet able to detect.

Asked about her present life situation, she claimed to be happily married, and said there were no difficulties of any kind in her life. She was unable to recall exactly when and under what circumstances her apprehension had started.

Throughout a series of interviews, she was finally able to remember that the anxiety attacks had begun six months previously, on one occasion when she was in the process of helping to admit a patient. What kind of a patient? A middle aged obnoxious alcoholic man, who became very boisterous and difficult to manage. "I was revolted by his behavior, his obscene talk and his fighting." She was so mad and started shaking so badly, that she was forced to leave the room.

A brief exploration of where such intense feelings could come from disclosed the picture of a very harsh and bitter childhood at the hanls of an irresponsible alcoholic stepfather, of whom the patient's mother was dreadfully afraid. There was also a suspicion that her husband, whom she had married because he seemed so reliable, had apparently formed an extramarital liaison.

This summary allows us to review a number of typical features in the average anxious patient.

Precipitating Event

There is usually a precipitating event or situation in the patient's *present* environment, which triggers the anxiety attack. Also very typically, the patient at first denies such an occurrence. In part, she is not really aware of the problem; in part, she is trying to protect herself from having to discuss with the physician intimate details of her life, which she considers embarrassing or painful.

One should never underestimate people's capacity for self deception. To kindly insist that there must be a recent cause for the disturbance, as the doctor knows from his long experience with this type of problem, is in the best interest of the patient.

It may be misleading to always think of clear cut, highly dramatic incidents. To be sure, this is many times the case; but long term common, disturbing family situations, form always the unavoidable background.

In the patient mentioned above, the fact that the husband was apparently running around was a clear indication that not all was well with the marital relationship. Her inane statements about the good state of her marriage obviously covered up a very intense fear of being abandoned by him, and a good deal of repressed rage about his behavior.

We should not be too hard on the patient's sincerity, as we all have an almost uncanny ability to deceive ourselves about the true nature of our actions.

A married woman, who lived with her aged, cantankerous and dominating mother, attributed her anxiety spells and fatigue to a lack of adrenalin in her system. Trying to convince her physician of the soundness of her explanation, she uttered this statement, "I have so very little adrenalin circulating in my veins that if somebody came in right now and told be that my mother just died, I wouldn't be able to move a muscle!"

The physician needs adequate knowledge of the sentimental intricacies of normal human relationships, to be able to understand the patient's true emotional situation. Ambivalence of feelings, the fact that most of our intimate attachments involve a mixture of sentiments (love and hate, resentment and tenderness), is a constant finding. When the relationship is threatened (separation, jealousy), the negative feelings come to the fore. This the anxious patient perceives as a serious danger.

An 18-year-old high school senior complained of inability to urinate in the presence of others at public rest rooms. This was very embarrassing to him, as he was a very shy person, to begin with, and blushed easily in situations of this sort.

A review of his family history showed his household was composed of a psychotic father, who had severe episodes of temper and depression including suicidal behavior; and a hard suffering mother, distant and aloof, but to whom the boy felt, nevertheless, intensely attached. With some encouragement, he was able to discuss his fear of going away to college, leaving his mother, as it seemed to him, in the hands of his father. The urethral inhibition in part represented his fear of attending college with boys whom he pictured as more grown up, mature and masculine than himself.

Inhibitions of this type very commonly hide a good deal of anxiety regarding adult relationships. Some anxious girls refuse to go out with boys "because I may have to go to the bathroom, and how would I explain that to my date." Looseness of the bowels is not an unusual physical symptom of fear.

I once treated a married couple who, after six months of marriage, were still unable to tolerate each other's presence in the bathroom. Not surprisingly, their main complaint was inability to have sexual relations.

Predisposition and Fears

As one takes the history, there are generally in the anxious patient, evidences of a tense, worrisome disposition, which goes back to childhood. Sensitivity to separation from mother, as for instance expressed in so called "school phobia," is not uncommonly elucidated.

School phobia, as most pediatricians know, is a misnomer for a situation in which a youngster manifests an acute fear of leaving home to attend school. Sometimes the child openly refuses to go; more often he suffers severe nausea, vomiting, stomach ache and fever. All these dramatic symptoms are quickly alleviated if he is reassured that he can stay home. If he is forced to attend school, as it is usually done when the family receives psychiatric help, he develops severe anxiety, and pleads to be returned home.

At the root of this condition there is usually a good deal of apprehension to leave the parents, particularly the mother, lest something should happen to her. Constant watching of his mother is the only recourse the youngster is left with, to reassure himself against the imagined effects of his own resentment. Families where this type of problem develops usually disapprove very strongly of any open expression of hostility.

If clear cut phobias do not appear in the history, one often finds subtle evidences of inhibition. Patients describe themselves as little boys and girls who seem to have been better behaved than average, all of the time. Such extreme fear of disap-

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proval is incompatible with a normally contented youngster, at least in our culture.

Somatic Preoccupation

Fears of a "heart attack," as the patient mentioned above suffered; "hypertension," "cancer," etc., are very common. They represent a convenient peg to hang apprehensions on; and very frequently mask fears of punishment related to fantasies of giving in to forbidden aggressive or sexual desires.

Without realizing it, the patient reproduces forgotten concepts of the time when he was a child, and was taught that if he behaved himself, nothing bad would ever happen to him; or the ideas of primitive people, who fear sickness as a punishment from the gods. This return to earlier, previously surmounted infantile modes of thought is called *regression,* and is a very striking characteristic of the anxious patient.

At times the situation is complicated by the presence of true organic disease.

A 43-year-old salesman was referred by his cardiologist because of the patient's seeming inability to accept the reasonable restrictions imposed by his coronary artery disease. The patient described himself as a highly driven man, who was used to working 12 to 14 hours a day; and for years had had little time or interest for anything else in his life. He was married to a very passive, inhibited, highly religious wife; they had two boys, and the patient was very strict with them.

There was an older brother, with whom the patient as a youngster had been very competitive. "He was so good in sports, and my parents liked him so well, you might say I lived under his shadow," the patient stated. He admitted being unreasonably angry about his heart condition, feeling that to have to slow down because of the illness was "adding insult to the injury."

He was unable to see or admit to himself that jealousy of and competition with his older brother were serious unresolved problems, despite the fact that in a second interview, he described many vicious fights with him. The brother was older and stronger, and "used to hit me right here, where I now get the pain."

Principles of Early Management

The anxious patient is caught in the throes of an emotional conflict within himself, which he does not understand and of which he is not even clearly aware. The anxious attack has been precipitated by an emotionally charged incident or situation, but the patient has usually "forgotten" the incident, and is leary of discussing it. There are evidences of childhood fears or apprehensions, and a good deal of somatic preoccupation. The patient is more willing to discuss symptoms, than he is life circumstances connected with them.

The Physician's Reaction

The doctor's initial response to the anxious patient determines to a large extent whether the patient will be helped or not. The patient is scared, and in a state of crisis, but the situation of danger the patient fears so much is usually not as grave and serious as he assumes.

The fear has to be accepted and understood, remembering the simplified list of developmental apprehensions listed above. The patient is a bona fide sufferer, a legitimate medical patient, and there is no point in minimizing his preoccupations.

A very common pitfall is to try to reassure too much and in too general a way. A psychiatrist of vast experience, Professor Raymond Waggoner, pointed out recently a not unusual happening between physician and nervous patient.

The patient himself may ask, "Should I see a psychiatrist, doctor?" The physician responds confidently, "A psychiatrist? Why, you are not crazy, we'll find out what's wrong with you!" At the end of a negative study, however, he is confronted with the fact that the patient does need psychiatric help.

It is much better not to prejudge, and to have a clear and open attitude about emotional problems.

Preventing Further Regression

By the time one has finished the history and physical examination, he has some understanding of the problem. This explanation should be given to the patient in terms he can understand, encouraging him to bring up any questions he may have. If one has been able to come to such a conclusion from what the patient has said, one should emphasize time and again that his symptoms reflect unresolved problems and chronic unmastered fears.

This does not preclude further examinations, and in fact it is important to keep in mind that emotional and organic problems do not exclude each other. The doctor has to carry this burden; it can not be shifted to the patient alone. The ideal situation is one of a healthy partnership, with both doctor and patient working together.

Accepting the Patient as He Is

Anxious patients are not necessarily, and certainly not immediately, reassured by a friendly and firm physician, who seems to know what he is doing. Some of these patients know only too well what murderous thoughts may be hidden behind an aura of friendliness.

Time heals; and it is of the essence in mastering problems. The doctor and the patient will have to have time to get better acquainted with each other, and learn to understand and resolve conflicts.

A woman who is tempted to divorce her abusive husband, but has a sense of obligation towards the children and is afraid to go it alone, is not going to find it easy to make a decision, even after she recognizes the real problem.

On the other hand, we know people do make decisions as difficult as this, and carry through with them, particularly if they have some encouragement and support. A beautiful novel by a psychiatric patient who recovered from schizophrenia after many years of treatment, was titled after the phrase used by her woman psychiatrist early in treatment to explain what the patient could expect. "I never" the doctor said, "promised you a rose garden!"[2]

Reluctant, withdrawn or very frightened patients who take their time to warm up to any kind of relationship, teach the physician the old virtue of the obstetrician, patience. The larger the number of anxious individuals the doctor sees, understands and treats, the easier it becomes to manage them scientifically.

Relatives

It is always useful to see important relatives, either by themselves or accompanied by the patient; and a similar tactful attitude is necessary with them. If their questions are truthfully answered, and they are ready to listen, one can correct many common misconceptions.

The idea that physical symptoms may spring from disturbed relationships to others is a new and threatening one for most people; it forces them to face feelings and thoughts that are usually not pleasant. And yet, if there is to be any relief to the situation, the interpersonal difficulties have to be resolved.

Prevention

It is not an idle exaggeration to say that all patients who come to a physician for help are potentially anxious patients. Unfortunately, many times the physician complicates the problem by over-reacting to it.

A 20-year-old pregnant housewife with mild anxiety symptoms was seen in the hospital after she "went to pieces." In discussing with her obstetrician her fears regarding delivery, he abruptly cut her off and declared that she "belonged on the fifth floor" (the psychiatric unit.) Acceptance of her many fears, and her right to express them, brought immediate relief to her face. She compared this incident with another experience she

had as a very scrupulous adolescent, when an understanding minister had reassured her about her fears of sin and sexuality.

Prognosis

Anxiety can, in some ways, be compared to fever; the presence of moderate anxiety indicates a reasonably well functioning mind. If the patient trusts the physician, and the physician can tolerate the anxiety compassionately, without over-reacting to it, the prognosis is good. One does not try to suppress fever, except when the fever is high or otherwise troublesome, unless one has some idea of its etiology.

With good psychiatric consultation available, the physician can handle the vast majority of uncomplicated cases of anxiety. Even when he refers patients to the psychiatrist, his interest and collaboration with the specialist can do a great deal to get the patient on the road to recovery, and further emotional growth.

Summary

The anxious patient presents a syndrome characterized by signs and symptoms of fear, but he usually does not know the cause of his apprehension. There is commonly a situation in the patient's environment which he perceives as dangerous, because it stimulates forbidden feelings within himself.

It is the physician's function to first understand the situation, and then slowly convey his knowledge to the patient, within the framework of a trusting doctor-patient relationship. If this can be done, improvement usually follows. ☐

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Employing the Diabetic

Like the legendary Phoenix new problems rise from the ashes of problems solved. Such is the situation in employment for the diabetic.

Fifty years ago, diabetes in a child or young adult meant total invalidism and early death. Today, with the proper use of insulin and oral hypoglycemic agents, diet and education, diabetics can expect a long life with uninterrupted periods of full activity. Though morbidity may be higher with inadequate metabolic control, the average diabetic rightfully shares the hopes and aspirations of his non-diabetic peer.

One hope is regular employment.

Yet nowadays, the certainty of employment for the otherwise healthy diabetic remains elusive because there exist problems real to both the employer and employee.

The likelihood of employment relates to jobs available, to individual ability, to an assurance of minimal absenteeism and to the potential financial liability assumed by the employer. In a tight labor market with many jobs and few applicants, the employer will overlook certain deficiencies in the employee as long as he can do the work. When a plethora of applicants exist, the qualifications of the individual are more carefully scrutinized. Individual ability means what a man offers to the labor market. Thus, the skilled worker or specialist rarely wants for work while obversely, the semiskilled or unskilled laborer often is unemployable.

The cost of benefits which may accrue to an employee from his group insurance, pension plan or workmen's compensation may affect his employability and may restrict the selectivity of the employer. Thus some employers may not hire certain workers because of "third-party restrictions." In many large industries, hiring involves more than the desire of a man to work and of a boss to hire.

Employment without regard to health and ability is not a right. Diabetics must understand this. They are wise to obtain as much education as possible. Not only should they aspire to positions where the vagaries of their disease are minimized, but they must also achieve a work record of high quality so that their non-diabetic fellow-workers and employers will learn that diabetics are worthy of their hire.

Employers should not prejudge diabetics; let them judge each man's potentiality and performance individually. Prejudices toward employability should not result from one or two bad experiences.

Should an inept left-handed employee jeopardize the employability of all southpaws?

Indeed not, nor does it follow that one diabetic with a high absentee rate mirrors the performance of all diabetics. Let all employers individualize the diabetic applicant. Though all the applicants have the same metabolic disease, varying degrees of severity and potential hazard exist. We feel that unconditional refusal to consider the employment of any diabetic is anachronistic. We want to persuade employers that this opinion is reasonable and defensible. Evidence exists showing equal absenteeism in diabetic workers when compared with employees without diabetes.

To help employers judge the applicant with diabetes on an individual basis, the Michigan Diabetes Association has developed an "Employment Classification." We hope it will serve as a guide toward unbiased judgment of the diabetic applicant by helping the employer individualize his decision.

The degree of severity of an applicant's diabetes together with the frequency of his visits to his physician serve as the basis of the Classification (Table 1). Thus the insulin-dependent diabetic (III-IV) should visit his physician more often than the mild diabetic (I). Generally the more often, within reason, a diabetic visits his physician for medical evaluation, the better will be the regulation of his diabetes. Greater stability means fewer medical problems may develop which might interfere with his employment record or create a work hazard. We know also that the optimal frequency of visits to a physician by a diabetic relates to the nature of his diabetes.

While the severe diabetic needs insulin, in the milder diabetic a diet alone or the concomitant use of an oral blood-sugar-lowering agent will suffice. Diabetics in the latter category usually in-

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This is a statement prepared by the Michigan Diabetes Association Committee on Employment. The approach is practical and highly commendable as a model to be followed by others similarly concerned with employing people with handicaps of a chronic nature. Members of the Committee are Fred W. Whitehouse, M.D., Chairman; Nelson Taylor, M.D.; George Thostenson, M.D.; Douglas Wood, M.D.; William Jend, M.D.; William L. Lowrie, M.D.; and Martin Burton, M.D.

— The Editor

DIABETES AND EMPLOYABILITY: CLASSIFICATION

Current Treatment Status of Diabetes	History of Professional Care A Sees Physician at least four times a year	 B Sees Physician as necessary, but at least once a year	 C Sees Physician less than once a year
I. Diet Alone	1	1	2
II. Diet and Oral blood-sugar-lowering agent	2	3	4
III. Diet and Insulin	3	4	5
IV. History of Frequent Hypoglycemic Episodes	4	5	6

This scale is an index of the relative stability of the applicant's diabetes. The scale ranges from Grade 1. (most favorable for employment) through Grade 6. (least favorable for employment). Factors such as job hazard, the Company's employment policy, insurance status, etc., must be considered on an individual basis.

clude those workers who develop their disease in middle-life after years of fruitful employment. The former group, the younger diabetics, present greater vulnerability, yet more frequent visits to a physician by this diabetic seem to offer greater physical stability.

By using this classification, we hope employers and their medical advisors will feel more confident in their evaluation of the individual applicant with diabetes. This classification will not answer all individual problems; no classification will do that. However, we hope use of this classification will permit one to judge a diabetic individually rather than as an unidentifiable member of a large group.

Some physicians may object to this classification because the degree of metabolic control is unspecified. What is control? Even experienced physicians disagree. This classification assumes that control of the diabetes will be affected by the regularity with which a diabetic visits his physician. The more insulin-dependent the diabetes, the more often the diabetic should visit his physician for re-evaluation of the diabetic state.

Others may say that nowhere do we mention the complications of diabetes. If there be neuropathy, diminished vision, or a circulatory problem, consider this on its own merit (or demerit). We believe that a complex classification with awkward criteria will hinder its applicability. This classification seems sufficiently practical to warrant a trial. The Michigan Diabetes Association hopes to do this. We hope individual physicians who face the problem of giving opinions on risks or lack of them in hiring the diabetic will use this classification. Any physician may obtain copies from the Michigan Diabetes Association. □

American Medical Care —Fact and Fancy

BY PAUL S. FRIEDMAN, M.D.
PHILADELPHIA

We, the physicians of America, are eager to participate in a continuing dialogue with the American people, so that through our combined efforts, the best medical care at the lowest possible cost will result. We particularly want to bare to the American people our goals, our aspirations, and our accomplishments, from a vantage point of truth, to serve better the people of the United States.

The medical profession welcomes constructive efforts at criticism. In fact, it participates in self-evaluation continually. Certain critics and criticisms, however, are unjust. Instead of collecting the facts objectively, and drawing conclusions from them, some critics start with unfair prejudgments, and then distort the facts, creating untruths and half-truths to support their conclusions. It is our responsibility to our patients that demands that we correct this misinformation, for such misleading information can be damaging to them when they are being treated, causing confusion and distrust.

The following are just a few examples of these unfair criticisms and the facts about them.

Number of medical colleges, medical students, and physician population.

It has been unfairly maintained that the medical profession and the American Medical Association are attempting to restrict the number of medical colleges and students. The reverse is true. The American Medical Association has stimulated new schools, frequently advising groups, planning and developing new schools. Since 1947, 11 new schools have opened, totaling 88; and by 1970 an additional 13 will be in operation, totaling 101. Six more are assured and another six are possible by 1975.

The American Medical Association supported legislation providing federal funds for medical college construction.

In addition, the American Medical Association and its branches, the state and county medical societies, have embarked on recruiting programs for medical students.

The American Medical Association has established a loan guarantee fund, to give financial assistance to medical students, interns and residents, supported by voluntary contributions of physicians, medical associations, private companies, and foundations. Over $35 million have been lent since the fund's founding in 1962. In addition, loan funds are available through state and county medical societies.

In 1960, there was one physician for 737 people; in 1965, there was one for every 681, a faster rate of growth in physician population than general population.

In the past, efforts to predict future physician needs have been most inaccurate. In 1959, the Bane Committee gloomily predicted we should never reach by 1975, the needed total of 330,000 physicians including osteopathic physicians. Actually, there will be a minimum of 360,000 physicians by 1975, exclusive of osteopathic physicians.

There has, however, been a functional and geographic maldistribution of physicians. There has been a marked reduction in the number of family physicians. This has been strongly influenced by the tremendous overemphasis on specialization and research in the medical colleges, largely stimulated by the unbalanced influx of federal funds into these areas. At the present time, efforts are being made to restore the family physician to his central role in American medical care.

An American Board of Family Medicine has been created and the American Medical Association has recognized Family Medicine as a specialty in medical practice. Recently, the American Medical Association commissioned a Report of a Citizens Commission on Graduate Medical Education. Many recommendations are to be implemented, such as a residency training program in family medicine, encouragement of group practice among family physicians and others, staff appointments and full practice privileges for family physicians on hospital staffs, as well as integrated programs in medical colleges, staffed by family physicians, to stimulate training and interest in family medicine.

There has been a tendency for physicians to concentrate in metropolitan areas, with resultant

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(Editor's Note: This article is reprinted with the permission of both the Nebraska State Medical Journal and the author.)

diminished concentration in other areas. To offset this, the American Medical Association in conjunction with the Sears Roebuck Foundation has been sponsoring rural location of physicians. The Kansas Rural Health program, developed by Dr. Franklin Murphy, has been most successful, in supplying rural medical needs. It involved the enlargement of the capacity of the Kansas Medical School to train medical students, the creation, through voluntary local fund raising, of facilities for medical practice throughout the state. Then a program of continuing education for rural physicians was set up consisting of two parts: 1. Traveling teams of consultants originate from the medical college and hospital, to visit different areas of the state throughout the year, holding clinics and offering consultation. 2. Rural physicians return to the medical college periodically for several weeks to months of refreshing training.

Many state societies have placement programs for physicians. Emergency medical services have been instituted by many county medical societies.

In addition, the tendency to overload full time staffs of medical colleges and larger hospitals must be reversed; this, too, is contributing to the maldistribution of our younger physicians.

Quality of medical care. Improperly documented criticisms of the quality of American medical care have been publicized. In many cases, these have used data originating in articles written by physicians, for self-evaluation and for education of their colleagues; incomplete information has been abstracted to support untrue conclusions.

A published article has been referred to as reporting that 90% of 21 surgical deaths in infants and children was the result of doctor error, and therefore evidence of poor medical care. But this study involved more than 4,000 operations in a single hospital, over a 10 year period beginning in 1947, 20 years ago; among the 21 there were many serious abnormalities at birth; and the article further stated, "There has been a dramatic decrease in operative deaths during the past four years, 1958-1961."

In other cases, efforts are made by critics to use statistics, usually from England and Sweden, to attempt to prove that the practice of medicine in the United States is inferior. Actually, if true statistical comparison can be made, it demonstrates that American medicine is second to none.

Basically, however, when comparison is made between one nation's statistics and another, comparisons may not be occurring between exactly the same events.

For example, Sweden's infant mortality rate is 1% below that of the United States. But, in Sweden, a baby is not alive until he breathes; such a baby's death would be called foetal death. In the United States, the presence of a heart beat or voluntary motion would classify the baby as alive, and subsequent death would be classified as infant mortality. Furthermore, the frequent use of abortion, in Sweden, alters these statistics further.

Further, while it is true that the average Swede lives to age 73, and the average American to the age of 70.3, a Swede in Minnesota outlives a Swede in Sweden.

As Waldo Von Greyerz, M.D., Swedish delegate to the World Medical Association pointed out, "I don't know how you would compare medicine in Sweden . . . with medicine in America. It surely can't be done with infant mortality and longevity statistics. People who compare such things obviously are hunting for headlines."

There are numerous other areas in which similar unfair criticism is publicized. These include the relation of physicians' fees to the rise in cost of medical care, the position of the medical profession and the American Medical Association to change and new legislation, the need for further governmental involvement in the distribution of medical care, among others. There is no question that continuous change and improvement is necessary to keep the quality of medical care in the United States at its high level and keep the cost as low as possible. The physicians of America are committed to that goal.

Let us remember, however, that the medical encounter involves the relation between a patient in distress and a physician equipped mentally, spiritually, and technically to relieve that distress and to prevent its occurrence. In making changes, let us preserve this as the basic component of high quality care.

The people of America are fortunate in having the finest medical care structure the world has ever seen. Let us recall that this has resulted because of the basic emphasis upon the individual patient physician encounter, with the physician basically and primarily responsible to that patient. Let us recall that this development has occurred in a basically private enterprise system, with the vast proportion of the financial support coming from private funds. Let us recall that nowhere else has there been such a development of voluntary nongovernmental health insurance. Let us remember that in those countries where the influence of government through the use of tax funds and control, has become dominant in the medical structure, that the quality of medical care has declined and the cost has excessively risen.

There is much to be done. There is a great need to restore the family physician to his primary position in American medical care; there is a great need to foster increased group activities among physicians, but always preserving the basic physician patient bond; there is a related need to restructure the medical college curriculum to reduce the emphasis upon accumulation of unending data by the student, with accompanying emphasis upon scientific knowledge as an end in itself, and return to basic principles with emphasis upon the humane and spiritual goals of the physician, using scientific knowledge as a tool for the help of patients. Related to this, there is the requirement that funds be redistributed in the medical colleges to meet these goals; the family physician must be given a position of significance and responsibility in both the hospital and medical college; with the resultant deemphasis upon unnecessary consultation and unnecessary laboratory studies, often done as a routine, rather than as indicated. As this is done, cost will be reduced; investigation and research must be supported, but not to the exclusion of providing individualized high quality patient care; the voluntary health insurance program (commercial insurance, Blue Cross-Blue Shield) must be continually expanded and strengthened to help the American citizen provide for the cost of medical care; government participation through the use of tax funds should be limited to those who financially require such help, and should be furnished through the states; governmental control and intervention should be resisted and minimized. There are many other vital goals.

Let all of us, physicians and citizens of the United States, join in a continuous program of change to improve further the quality of medical care and reduce the cost as much as possible. Let us guard against change, however, which will destroy the basic ingredients which have made American medicine great. ☐

Children's Bureau Lists Possible Issues for '70 Michigan Conference

Plans for the 1970 Michigan White House Conference on Children and Youth are being developed now by the Michigan Youth Commission.

The conference planning committee has decided to build its work around the age group of "Minus Zero to Five Years." The conference will study how these small children and their parents "are affected by the tensions, concerns and anxieties of depravation and affluence."

Medical society leaders will be interested in six suggested conference issues proposed by the Federal Children's Bureau for the 50 state conferences. The six issues included:

"1. How it is possible to satisfy the growing urge on the part of the youth for direct participation in decision-making in those areas which directly affect them, and still maintain clearly established areas for final authority?

"2. In what ways should legal protection and rights of children and youth be strengthened or modified?

"3. Where does the youth's individual right and responsibility for defining the limits of sexual behavior leave off, and the societal begin?

"4. How can the numerous educational tasks in the society be distributed so that young people have access to the learning situations they want and need?

"5. What frontiers of individuality should today's children and youth seek?

"6. How can we redirect our societal dynamics in order to emphasize human development?" ☐

Special "Ars Medica" Exhibition Being Brought to Detroit as Feature For MSMS 1968 Annual Session

BY ELLEN SHARP

CURATOR OF GRAPHIC ARTS
DETROIT INSTITUTE OF ARTS

Ars Medica is the title of an exhibition of prints depicting medical subjects which will be shown at The Detroit Institute of Arts from September 22 through October 20, 1968. This exhibition has been arranged in cooperation with the Institute's Department of Graphic Arts and a special committee of physicians especially for the 1968 Annual Session of the Michigan State Medical Society in Detroit, September 25-26.

The exhibition will consist of over 130 original works of art representing all types of graphic media—woodcuts, engravings, etchings, lighographs and serigraphs. The prints are grouped in 21 different categories.

SOME OF THE subjects covered are Hospitals in Peace and War, Hygiene and Preventive Medicine, Medical Teaching, The Madhouse, and Allegories of the Healing Arts.

One of the earliest prints in the exhibition is a woodcut from Ketham's *Fasciculus Medicinae* published in Venice in 1493. Entitled "The Zodiac Man" it is the oldest printed bloodletting chart.

A fine impression of the first etching by the great German graphic artist, Albrecht Durer, *Plate of Sketches,* depicts the four temperaments (or dominant humors) — the choleric, sanguine, melancholic and phlegmatic.

A Sixteenth-century etching by Abraham Bosse illustrates one of the commonest therapeutic measures of that era — phlebotomy. This print is characteristic of Bosse's work showing the life of the upper middle class in France with a wealth of detail.

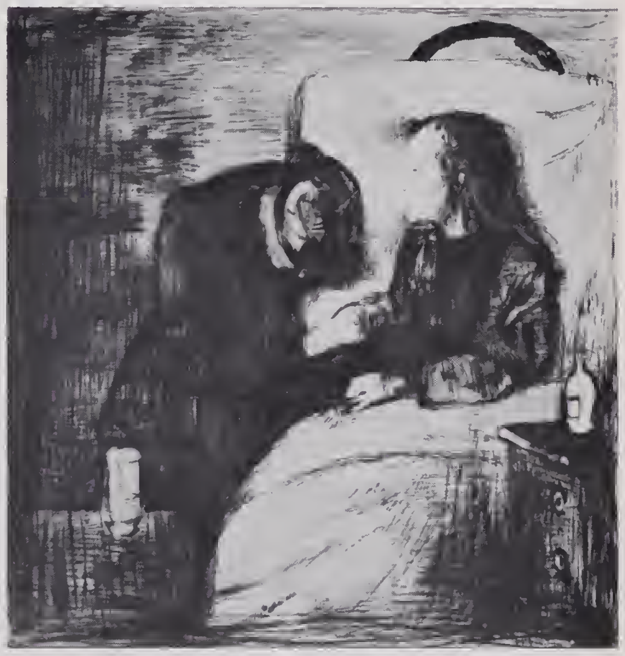
A pioneer example of color printing, developed in the Eighteenth century, is Jacques Gautier Dagoty's mezzotint *Muscles of the Head,* plate I from *L'Anatomie de la Tete,* Paris, 1748.

The great caricaturists and humorists of the eighteenth and nineteenth centuries did not neglect the medical profession. Thomas Rowlandson, George Cruikshank, James Gillray, Gavarni, and Honore' Daumier are represented in the exhibition.

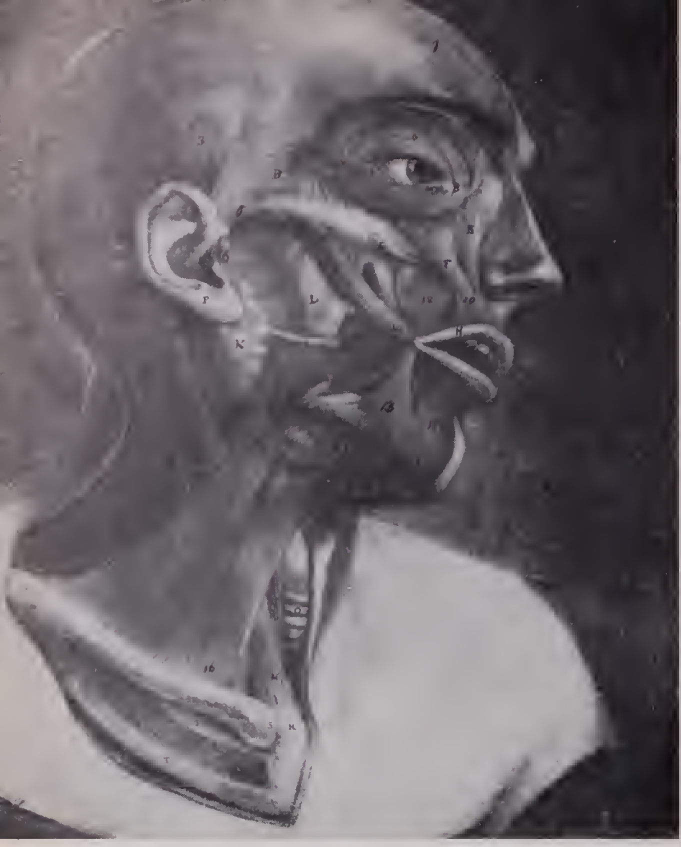
Moving and powerful works by modern artists with medical themes are prints by Edvard Munch, Kathe Kollwitz and Michael Mazur.

SOME OF THE MOST interesting prints in the exhibition are portraits of great physicians of the past, such as Paracelsus, Ambroise Pare', Andreas Vesalius, William Harvey, and Carolus Linnaeus.

One section of the exhibition reminds us that medical men often have distinguished themselves in the arts. Especially notable have been the contributions of members of the medical profession to literature. Engraved portraits of Francois Rabelais, French writer and a member of the faculty of the great medical school of Montpellier, and of

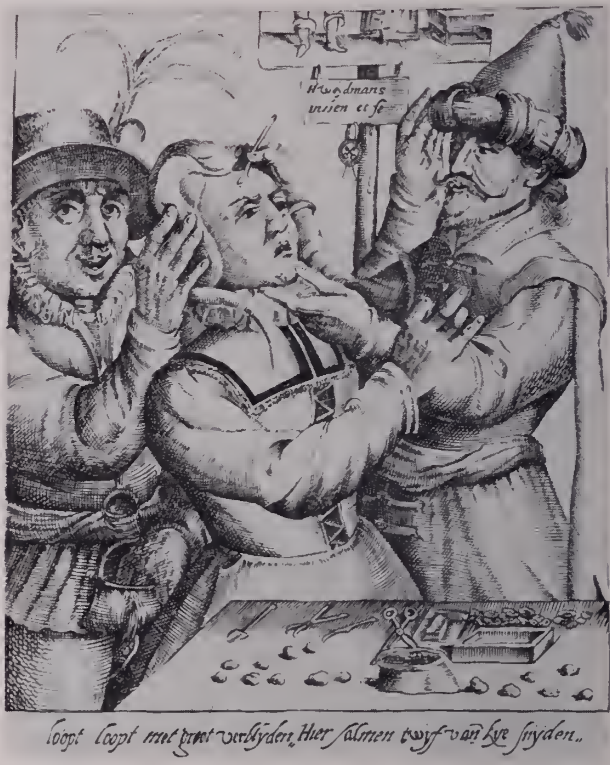


The Sick Child 1894, a drypoint, was made by Edward Munch (Norwegian, 1863-1944). Drypoint is a process often combined with engraving and etching. A metal tool with a tapered point is used to scratch the design on the plate. The burr raised on the plate on each side of the line created by the drypoint tool produces a soft, blurred line quite different from the sharp, swelling line of the engraver's burin, or the flowing, thread-like etched line.

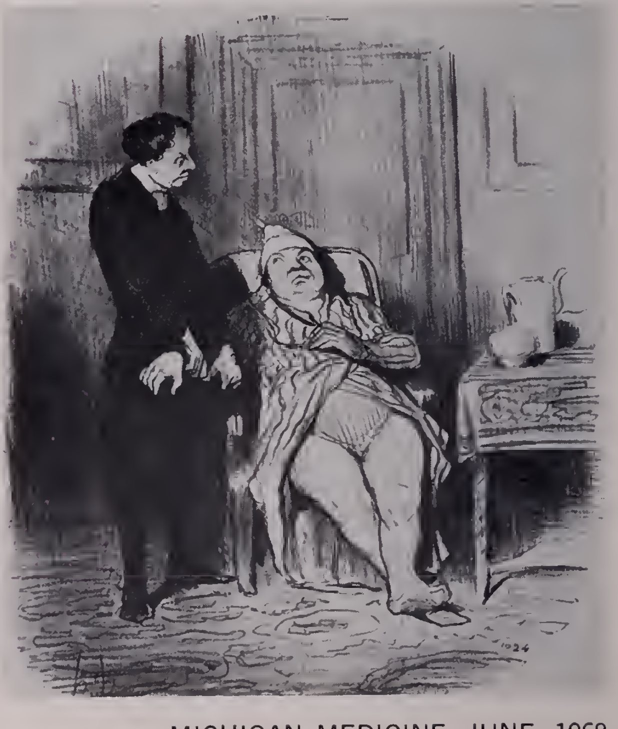


The Muscles of the Head, plate I of **L'Anaotomie de la Tete,** Paris, 1748, is a mezzotint printed in color by Jacques Gautier D'Agoty. A mezzotint is a print produced by a variant of the engraving process, developed to produce tone. A metal plate is roughened uniformly with a tool called a rocker which has a curved, serrated head; gradations of tone are obtained by scraping and burnishing away the roughened surface. The process, invented in the seventeenth century, was used extensively in the eighteenth century.

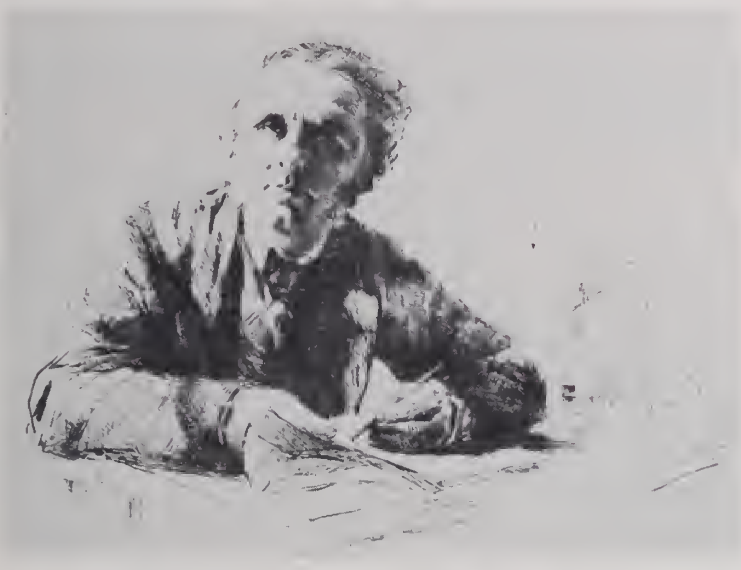
Operation for Stones in the Head, an engraving, was done by H. Weydmans (Dutch, early 17th Century). An engraving is a print taken from a metal plate on which the design has been incised with a sharp instrument, the burin or graver. The incised plate is inked, wiped and printed. The successful printing of a metal plate requires the pressure of a double-roller press to force the paper into the incised, inked lines.


H.Weydmans
inven et fe
loopt loopt met groot verblyden, Hier ſalmen twyf van kye ſnyden..

"Oh Doctor, I'm sure I'm consumptive" says the patient in this lithograph by Honore' Daumier (French 1808-1879). This appeared in a series **All One Could Wish For (Tout ce qui' on voudra),** Paris, 1847. Lithographs are made from a stone block (or zinc plate) on which the areas of the design have been drawn with a greasy substance applied by pen, brush or crayon. The design then is fixed in the stone by treating it with acid and gum arabic. For printing the surface of the stone is dampened and then rolled with greasy ink. The greasy ink adheres to the grease of the image and is repelled by the dampness from the rest of the surface. The inked stone is then printed in a press in which sliding pressure is applied rather than rolling pressure as in an etching press. For color printing, a separate stone is used for each color.



Self-Portrait 1862 is an etching by Sir Francis Seymour Haden, (English, 1818-1910). An etching is a print pulled from a metal plate which was first covered with an acid-resistant ground. The design is drawn through the ground with an etching needle. When the plate is immersed in acid, the plate is etched wherever the metal has been exposed by the needle. The plate is inked and printed in the same manner as an engraving. If the etcher wishes to reinforce certain lines on his etched plate, he repeats the etching process. That part of the plate not to be re-etched is covered with a stopping-out varnish before it is immersed in the acid bath.



Ellen Sharp, author of this article, is curator of graphic arts for the Detroit Institute of Art, shown at right. Miss Sharp, in presenting this special exhibition, has worked closely with a group of Detroit area physicians and wives interested in art. The key man in giving the go-ahead to the project was Willis Woods, director of the Institute of Art.

Sir Thomas Browne, the English philosopher and physician, will be shown in the exhibition.

The fine etched self-portrait by the distinguished surgeon Sir Francis Seymour Haden who was also a master of etching, takes on greater meaning for the viewer when it is considered in the light of Haden's own remarks in a lecture to the Royal Society of Painter-Etchers and Engravers:

"How much sooner would the eye — accustomed to observe and estimate closely the differences of color, aspect, weight and symmetry — learn to gauge their aberrations as the signs which make up the *facies* of the disease; how much better the hand, trained to portray them accurately, be able to direct with precision and safety the course of the knife!"

THE EXHIBITION COMES in its entirety from the permanent collection of the Philadelphia Museum of Art. Through the generosity of Smith Kline & French Laboratories, a special fund was created in 1948 for the purchase of prints of medical interest. Only one condition was placed by this pharmaceutical firm on its gift, namely that the objects acquired be worthy of inclusion in a museum collection. The choice was left entirely to the curator of prints at the Philadelphia Museum. The result is not only a collection showing the essential aspects of medical iconography in all its fascinating variety but also a group of prints distinguished for their fine impressions and high artistic quality.

Recently The Philadelphia Museum has announced the establishment of an Ars Medica Center at the Museum. This has been made possible by a major grant from the Smith Kline and French Foundation. Plans are underway not only to enlarge the collection of prints and drawings relating to the medical sciences but also to develop a reference file and an information retrieval system.

MOST OF THE principal "hand methods" of making prints are represented in the exhibition. The history of Western printmaking begins in the fifteenth century as paper, which had been first made in Spain in the twelfth century, became generally available throughout Europe. The first technique to be developed was the woodcut. It was closely followed by engraving and later etching. Lithography was not discovered until the end of the eighteenth century; silk-screen printing is a twentieth-century refinement of the stencil process.

THE PRINTS IN the *Ars Medica* exhibition will include prints made by other processes in addition to the examples reproduced in this article. The other processes include:

WOODCUT on the cover, to help promote the *Ars Medica* exhibition at The Detroit Institute of Arts during the 1968 MSMS Annual Session in Detroit in September, is attributed to the Woodshop of Titian (Italian 1477-1576), entitled *The Ninth Plate of Muscles* appeared in Vesalivs's *De Humani Corporis* Fabrica, Basle, 1543. The areas not to be printed were cut away from the woodblock and the prints were made by applying ink to the raised surfaces and applying hand pressure.

AQUATINT — a print produced by a variation of the etching process. Areas of tone are obtained by covering the plate with rosin dust, then heating it so that the particles adhere to the plate. The plate is immersed in acid and is etched wherever the particles have left the plate exposed.

SILKSCREEN (OR SERIGRAPH) — a variation of the stencil process. A finely-woven fabric, usually silk or nylon, is stretched over a wooden frame to form "the screen." An image or design is created by making some parts of the screen opaque and others open. Color pigment is then forced through the fine mesh of the open parts of the stencil by the use of a tool called a "squeegee."

The processes used for the prints reproduced in this article are explained under each print.

COOPERATIVE PROJECT . . .

This special *Ars Medica* Exhibition is being brought to Detroit September 22 through October 20 by the Detroit Institute of Arts and a group of Detroit area physicians and wives interested in art. The group has contributed the funds necessary to transport the exhibition from The Philadelphia Museum to Detroit so the exhibit can be an added attraction for the 1968 MSMS Annual Scientific Session, September 25-26. Members of the co-sponsoring group include Dr. and Mrs. Irvin F. Burton, Dr. and Mrs. Alfred Golden, Dr. and Mrs. James J. Lightbody, Dr. and Mrs. Paul E. Mattman, and Dr. and Mrs. Milton R. Weed.

Let's be specific about Campbell's Soups… and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

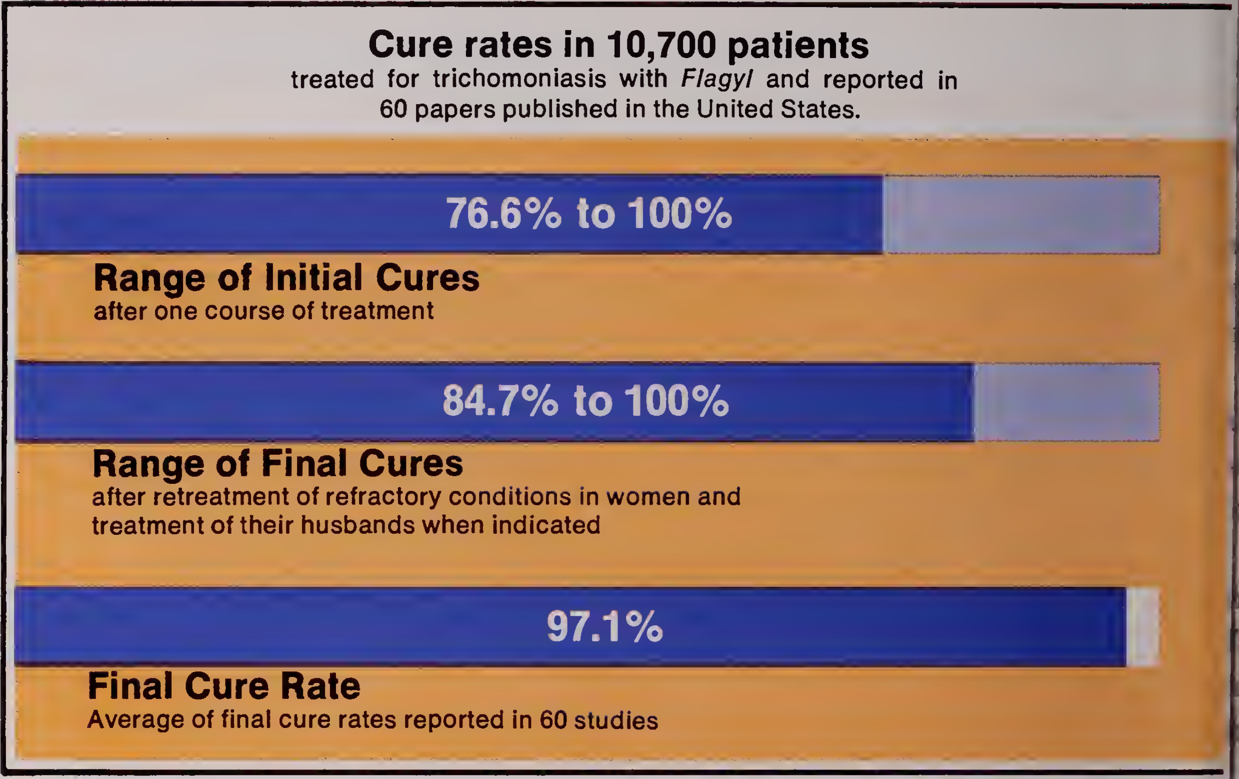
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Campbell's
CONDENSED
SOUP

True Drug Failure...

How often does it occur


Cure rates in 10,700 patients
treated for trichomoniasis with *Flagyl* and reported in
60 papers published in the United States.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongu
Gastrointestinal disturbances, flushing and hea
ache sometimes occur, especially with conco
itant ingestion of alcohol. The taste of alcoho
beverages may be altered. Other effects, all r
ported in an incidence of less than 1 per cent, a
diarrhea, dizziness, vaginal dryness and burnin
dry mouth, rash, urticaria, gastritis, drowsine
insomnia, pruritus, sore tongue, darkened urir
anorexia, vomiting, epigastric distress, dysur
depression, vertigo, incoordination, ataxia, a

vith Flagyl®?

brand of

metronidazole

clinical practice an occasional uncooperative or drug-sensitive patient spouse makes 100 per cent cure of trichomonal vaginitis in large series patients difficult.

Further a very few patients who apparently absorb Flagyl poorly d a few rare instances of trichomonads resistant to Flagyl have been ported. Nevertheless, approximately half the United States investiga-s report a final cure rate of 100 per cent with Flagyl.

Sixty papers[1] published on the use of Flagyl in trichomoniasis in the ited States and comprising a total of 10,700 patients have been evalu-d. In thirty of the papers it was declared that all patients adequately lowed and treated were free of trichomonal infection.

Analysis of all of these papers shows that the incidence of cures for *initial* course of therapy ranged from 76.6 per cent to 100 per cent. e cure rates after retreatment of female patients and treatment of their sbands when indicated ranged from 84.7 to 100 per cent. The average al cure rate reported in all investigations was 97.1 per cent.

minal cramping, constipation, stomatitis, mbness or paresthesia of an extremity, joint ins, confusion, irritability, weakness, cystitis, vic pressure, dyspareunia, fever, polyuria, in-ntinence, decreased libido, nasal congestion, octitis and pyuria. Elimination of trichomonads y aggravate candidiasis.

osage and Administration: In women: one 0-mg. oral tablet three times daily for ten days. vaginal insert of 500 mg. is available for local rapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

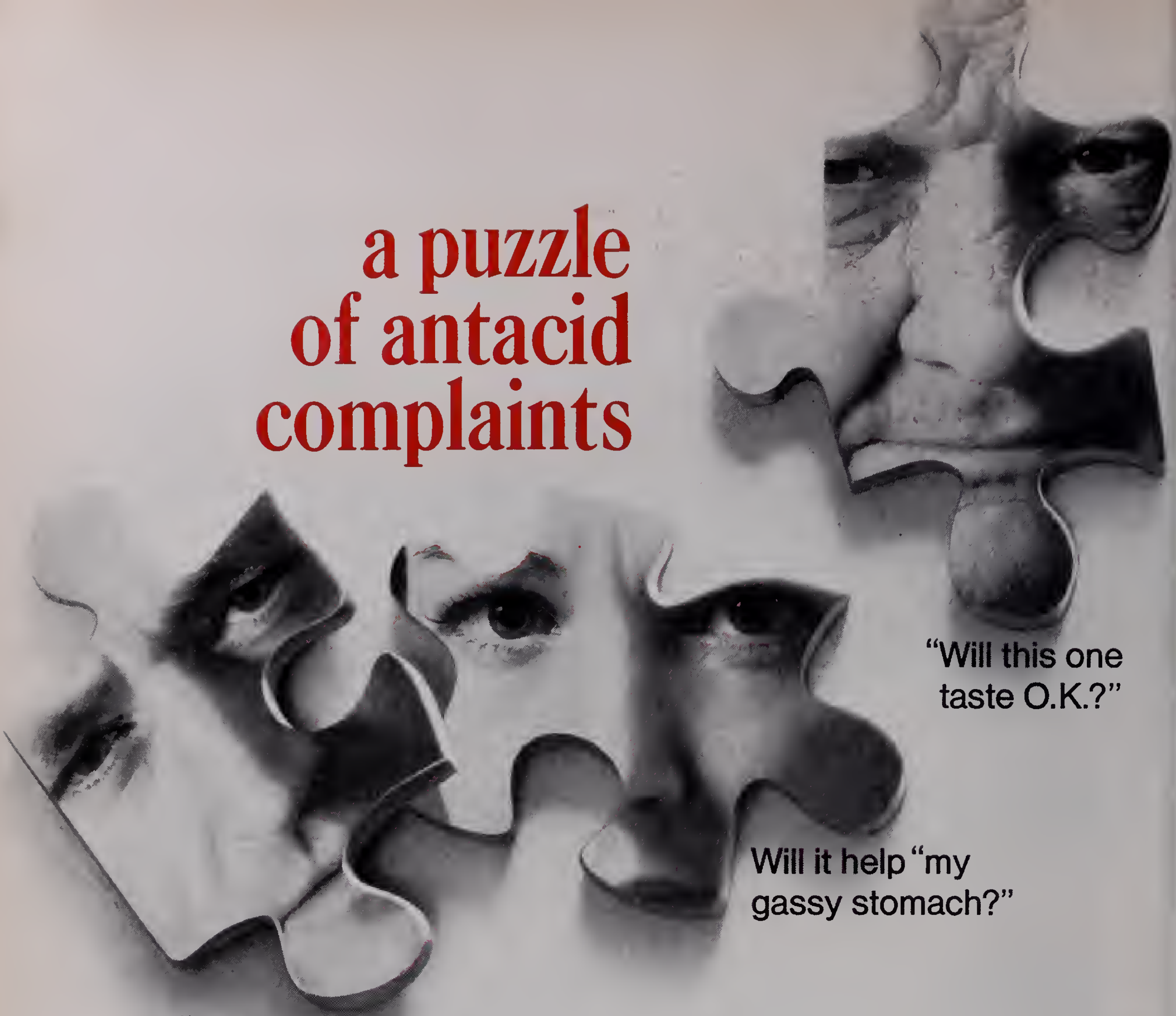
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets–250 mg.
Vaginal inserts–500 mg.

[1] *Complete list of references on request.*

SEARLE *Research in the Service of Medicine*

a puzzle of antacid complaints


"Will this one taste O.K.?"
Will it help "my gassy stomach?"
"Will it stop the pain?"

Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966. 2. Danhof, I. E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Invite Nominations For MSMS Honors

July 1 will be the deadline for component county medical societies which wish to offer nominees for the MSMS "Outstanding Physician of the Year Award" and for the MSMS "Certificates of Commendations."

The nomination forms and covering letters recently were sent to every county society.

D. Bonta Hiscoe, M.D., Lansing, is chairman of the committee to select the outstanding physician and Marjorie P. Meyers, M.D., Detroit, will direct the work of the other committee. Both were appointed by MSMS Speaker James B. Blodgett, M.D.

OUTSTANDING PHYSICIAN AWARD

The 1964 House of Delegates took action to establish annual recognition of Michigan's Outstanding Physician and the award was presented in 1965 to F. L. Troost, M.D., in 1966 posthumously to William A. Hyland, M.D., and in 1967 to Henry Cook, M.D., Flint.

The resolution adopted in 1964 by the Delegates provided that this recognition be given to a member of the profession, "who is not necessarily a family physician, nor one advanced in years . . ." The resolution resolved also "that consideration be given to the physician's civic accomplishments as well as his professional accomplishments."

CERTIFICATES OF COMMENDATION

The 1961 House of Delegates, in approving the Certificates of Commendation, pointed out that the new award "may include both scientific and/or public service and may be awarded to one or more physicians annually who distinguish themselves in the medical profession."

The House of Delegates has approved the recommendations each year of the Committee. The names of previous recipients are listed below:

1962

Jerome W. Conn, M.D., Ann Arbor
G. D. Cummings, M.D., Lansing
Charles S. Kennedy, M.D., Detroit
Robert L. Novy, M.D., Detroit

1963

Forest D. Dodrill, M.D., Bloomfield Hills
Charles J. Jentgen, M.D., Detroit
John M. Sheldon, M.D., Ann Arbor
Homer H. Stryker, M.D., Kalamazoo

1964

Goldie B. Corneliuson, M.D., Lansing
John S. DeTar, M.D., Milan
Robert M. Heavenrich, M.D., Saginaw
Norman F. Miller, M.D., Ann Arbor
E. Gifford Upjohn, M.D., Kalamazoo
Orus R. Yoder, M.D., Ypsilanti

1965

Fred J. Hodges, M.D., Ann Arbor
Traian Leucutia, M.D., Detroit
Remus J. Robinson, M.D., Detroit

1966

Arthur C. Curtis, M.D., Ann Arbor
Lionel L. Davis, M.D., Mt. Pleasant
Mark Marshall, M.D., Ann Arbor
Harold J. Meier, M.D., Coldwater
Ralph H. Pino, M.D., Detroit
Alfred B. Swanson, M.D., Grand Rapids
Harry A. Towsley, M.D., Ann Arbor

1967

Frank J. Busch, M.D., Saginaw
Willis Herbert Huron, M.D., Iron Mountain
Frederick J. Margolis, M.D., Kalamazoo
David I. Sugar, M.D., Detroit, (posthumously)
Raymond W. Waggoner, M.D., Ann Arbor
Charles H. Wright, M.D., Detroit

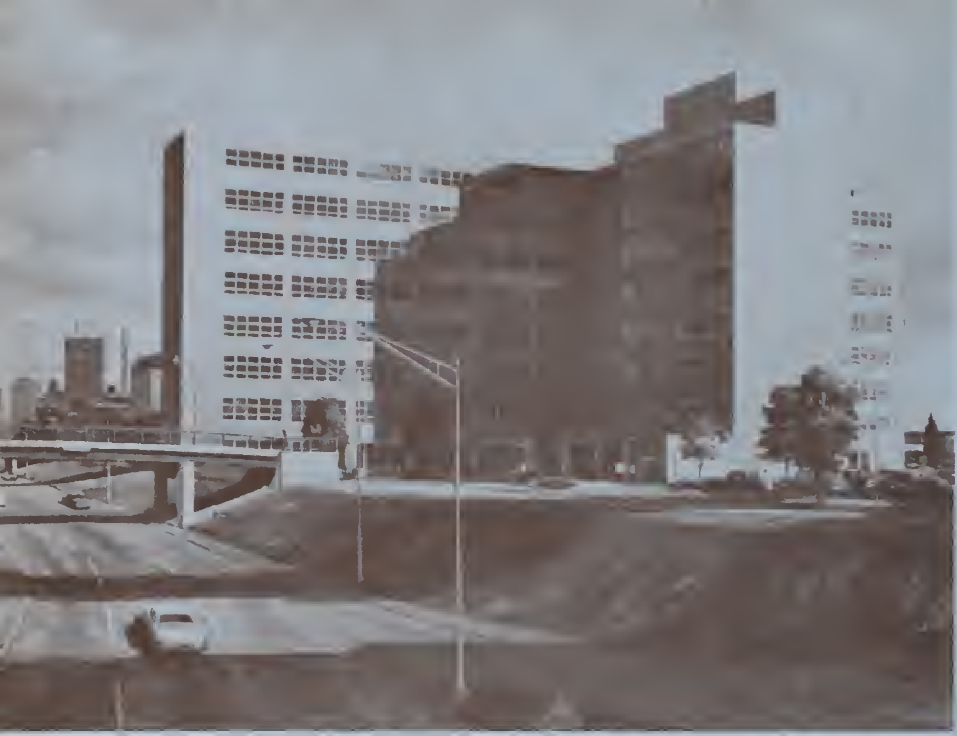
Sees Health Manpower Recruitment as Job For the Community

Recruitment to provide the right kind of persons to fill the rural health needs in Michigan and the nation "must be a total community effort," Robert E. Rice, M.D., Chairman of the MSMS Committee on Rural Medical Service, recently wrote to the MSMS Council.

Doctor Rice served recently as the MSMS representative to the National Conference on Rural Health in Seattle.

Doctor Rice, in his conference report to The MSMS Council, suggested eight possible implications for Michigan:

1. Develop more intensive and extensive First Aid Training.
2. Improve and coordinate emergency communications.
3. Improve transportation of injured.
4. Meld the will of people and needs of people with know-how of specialist.
5. Anticipate variegated forms of providing health care.
6. Develop awareness of needs of providers of medical care and other health care in communities, especially rural.
7. Continue to improve dissemination of medical knowledge to profession.
8. Include health care planning in total community planning.



SQUIBB PRESENTS WSU PAINTING TO HELP OBSERVE CENTENNIAL

E. R. Squibb and Sons, Inc., recently presented as part of the WSU Centennial, an original oil painting of the Wayne State University School of Medicine to its dean, Ernest D. Gardner, M.D.

Representing Squibb was Raymond J. Powers, Squibb vice president for market planning.

The painting which shows the Basic Science Building is the work of the well-known artist, Robert Lavin.

Dean Gardner felt that this particular view would be lastingly and sentimentally remembered by every graduate.

The painting is part of a long-range Squibb plan to create a collection of original oil paintings representative of the medical schools of America.

The U-M received a painting last year during its Sesquicentennial.

AMA Aids SAMA In Pilot Effort

A student-to-people project to communicate health information to residents of lower income indigent neighborhoods was announced at the recent SAMA annual meeting in Detroit.

David Kindig, SAMA president, announced that the AMA is financing a $39,000 pilot project in Kansas City to utilize freshmen in high school up to graduate medical students to personally contact and work with residents of indigent areas and inform them of existing medical facilities available to them.

SAMA will administer the project and its Kansas City chapter will spearhead the effort in cooperation with other local organizations.

"In Kansas City, medical students have managed to smash the wall of mistrust between the 'haves' and 'have-nots' by demonstrating a determination and willingness to work with the people on their terms, in their neighborhoods," said Kindig in his comments to the SAMA convention.

MSMAS Plans July Seminar

"Education" is the key word for the 1968 Summer Seminar of the Michigan State Medical Assistants Society. This year's Seminar is to be July 20-21 at Boyne Highlands, Harbor Springs, Michigan.

Designed as an annual event for continuing education of medical assistants, the two-day meeting will feature physicians speaking on a variety of subjects. Included will be: Robert I. Goldsmith, M.D., assistant professor, Department of Ophthalmology at the University of Michigan, on "Some Common Misconceptions in Eye Disease."

Paul W. Gikas, M.D., associate professor, Department of Pathology at the University of Michigan, will speak on "The Pathogenesis of Fatal Injuries in Highway Accidents."

"A Working Philippine Vacation, Experiences Unlimited" is the topic of Sidney N. Smock, M.D., Midland anesthesiologist, who will deliver the banquet address on Saturday evening, July 20.

A panel discussion will comprise the Sunday, July 21, program. Speaking on "The Medical Assistant and Office Management" will be R. Timothy Hogan, member of the Board of Directors of Professional Management, Ann Arbor. Marcus L. Plant, J.D., professor, University of Michigan Law School, will discuss "The Medical Assistant and the Law."

"The Medical Assistant and Public Relations" is the topic of Barry H. Alford, M.D., Plymouth, Chairman of the advisory board of the Washtenaw County Medical Assistants and member of the MSMAS Advisory Committee. Winslow G. Fox, M.D., Ann Arbor, Chairman of the MSMS Medicine and Religion Committee will discuss "The Medical Assistant and the Patient with Special Needs."

Chairman of the 1968 Summer Seminar is Mrs. Patricia Austin of Ann Arbor.

Busy H/D Committee Chairmen

The committees of the MSMS House of Delegates are hard at work completing assignments and reports for the September session. The following men have been appointed as chairmen by Speaker James B. Blodgett, M.D.:

COMMITTEE TO RE-EVALUATE THE DUTIES OF THE PRESIDENT – C. Allen Payne, M.D., Grand Rapids

COMMITEE ON MEDICAL STAFF SURVEY OF HOSPITALS – Rosser L. Mainwaring, M.D., Dearborn

COMMITTEE ON CERTIFICATES OF COMMENDATION – Marjorie Peebles-Meyers, M.D., Detroit

COMMITTEE TO SELECT MICHIGAN'S OUTSTANDING PHYSICIAN – D. Bonta Hiscoe, M.D., Lansing

COMMITTEE ON PROCEDURES OF THE HOUSE OF DELEGATES – Noyes L. Avery, Jr., M.D., Grand Rapids

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE – John G. Slevin, M.D., Grosse Pte. Park

COMMITTEE TO STUDY FINANCIAL STRUCTURE OF MSMS – James D. Fryfogle, M.D., Southfield

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UP Medical Event June 21-22

Bradley M. Harris, M.D., MSMS President from Ypsilanti will speak at the Upper Peninsula Medical Society's 75th Annual Meeting at the Four Seasons Club in Pembine, Wisconsin, June 21-22, on "Tomorrow's Doctor."

MSMS Past President, George W. Slagle, M.D., will speak on "The Physician's Role in Use of Health Care Resources."

Ovid O. Meyer, M.D., professor of medicine at the University of Wisconsin, will talk about "Present Day Treatment of Leukemias and Lymphomas," and "Recent Advances in Treatment."

Other speakers are George E. Collentine, Jr., M.D., director of the Burn Center at St. Mary's Hospital in Milwaukee, who will discuss "Emergency Management of Burns;" Ralph L. Suechting, M.D., a neurosurgeon from Neenah, who will speak on "Post Traumatic Head Pain and Neck Pain;" James W. Nellen, M.D., orthopedic surgeon with the Green Bay Packers, whose talk is entitled "Strapping of Common Athletic Injuries;" and Ernest O. Henschel, M.D., professor of anesthesiology at the Marquette School of Medicine, who will talk on "Pre-and Post-Operative Medication."

Registration for the meeting begins at 5 p.m., June 20.

TO INVITE OSTEOPATHS

The Board of Directors of the Oakland County Medical Society recently passed a motion that the society pursue an active program of inviting osteopathic physicians to attend the society meetings.

Aiuto to Lead WSU Alumni

New officers for the Wayne State University School of Medicine Alumni Association were elected at the Centennial Clinic Day and Alumni Reunion in Detroit May 15.

James Aiuto, M.D., Grosse Pointe, took office as president along with Frank B. Walker, II, M.D., Grosse Pointe, and William A. Harrity, M.D., Grosse Pointe, as president-elect and secretary, respectively. Warren O. Nickel, M.D., Dearborn, continues as treasurer.

Elected to the Association's Board of Governors were Doctors James J. Horvath, Grosse Pointe; Charles C. Vincent, Detroit; and David Jacknow, Huntington Woods.

Outgoing president is Mario A. Petrini, M.D., Detroit.

NOW IN VIETNAM

Most recent Michigan physician to leave for Vietnam under the AMA Volunteer Physicians for Vietnam program is Armand M. LaSorsa, M.D., of Manistique. Doctor LaSorsa, a general practitioner, left for South Vietnam in early May and will return in July.

"Formula for Progress Against Cancer" was the focus of a recent MAP TV broadcast by WJIM-TV in East Lansing. From left to right are Hugh Brenneman, MSMS and MAP Executive Director, who hosts the weekly program; Melvin L. Reed, M.D., of Detroit, associate clinical director of the Milton A. Darling Memorial Cancer Center and assistant professor of oncology at Wayne State University; Alan F. Phillips, M.D., of Flint, a radiotherapist at Hurley Hospital; Max E. Dodds, M.D., also from Flint, chairman of the MSMS Cancer Committee; and Helen Menton, producer of the show.

MAP Honors Gross, Nolen

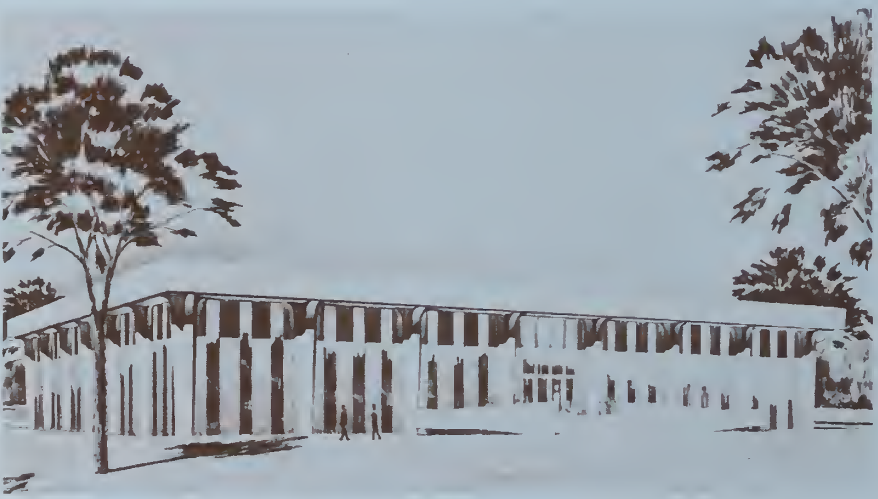
Harold F. Gross, president of Gross Telecasting Company (WJIM-TV and radio in Lansing) received the Outstanding Service Award, and John G. Nolen, D.D.S., of Lansing, received the Distinguished Award during the ninth annual Congress of the Professions, May 10-12 at Boyne Highlands.

The Outstanding Service Award is given annually to "An individual who has rendered greatest service to the professions represented in MAP." The Distinguished Award, also given annually, is for "One member of MAP who has made an outstanding professional contribution."

The Congress continued Luther R. Leader, M.D., Royal Oak, for a two-year term on the MAP board of directors. G. B. Saltonstall, M.D., Charlevoix, and J. Russell Brink, M.D., Grand Rapids, have another year to serve as members of the board. The board will elect officers at its next meeting.

Theme of the Congress this year was "Practical Aspects of the Professional Concept."

(Further details will appear in future issues of *Michigan Medicine*.)



WSU Medical Library Project Proceeds

Ground is scheduled to be broken this year for a $2,000,000 Shiffman Medical Library to be built by the Wayne State University School of Medicine. The project will be financed by a $1,432,246 grant by the Public Health Service of the U. S. Department of Health, Education and Welfare, a $500,000 gift from Abraham Shiffman through the Shiffman Foundation and $200,000 raised by the WSU medical alumni. Part of the alumni contribution will pay for furnishings, equipment and books.

The building will be located on the southwest corner of Brush and Canfield, near the medical school's Research Building and the Basic Science Building now under construction. Both Brush and Canfield will be closed and converted to pedestrian malls when the Medical Center is further developed.

Several physicians have worked to raise contributions for the new library through the Wayne University Medical Library Inc. headed by John Webster, M.D., fund chairman. Officers of the corporation are Drs. Edward M. Vardon, president; Don W. McLean, vice president; William J. Stapleton, Jr., treasurer; J. Courtney Fremont, assistant treasurer and Edgar C. Long, secretary. Alumni Director Homer D. Strong is assistant treasurer and resident agent.

BEEMAN, WILLIS ON HEART FORUM

Carl B. Beeman, M.D., of Grand Rapids, president of the Michigan Heart Association, moderated a public forum called "Hope For Your Heart" on Friday evening, May 10, at Ford Auditorium in Detroit, during the annual meeting of the Michigan Heart Association.

One of the speakers on the panel, co-sponsored by the Detroit *Free Press,* was Park W. Willis, III, M.D., professor of medicine at the University of Michigan Heart Station. Doctor Willis spoke on "Rheumatic Fever; High Blood Pressure."

The Nineteenth Annual Scientific Session of the MHA was well attended May 10-11 at the Rackham Memorial Building. Program participants included Michael C. Kozonis, M.D., Pontiac; Joseph N. Schaeffer, M.D., Detroit, and Henry H. Swain, M.D., Ann Arbor.

HEUSTIS, DANTO SPEAK AT ALMA CONFERENCE

MSMS was co-sponsor of a Physician-Clergy Workshop at Alma College on May 2 for Michigan clergy and physicians.

Physician speakers were Albert E. Heustis, M.D., director of Michigan Regional Medical Program and Bruce L. Danto, M.D., director of the Community Psychiatry Program for the Detroit Psychiatric Institute.

Keynote speaker was Rev. Robert B. Reeves, Jr., chaplain at Columbia-Presbyterian Medical Center in New York City.

DSA Hears Shumway

Over 200 physicians, members of the Detroit Surgical Association, heard Norman F. Shumway, Jr., M.D., who has done two heart transplants, speak on "Transplantation of the Heart," in Detroit on May 8. Doctor Shumway, professor of surgery at the Stanford School of Medicine, spoke at the DSA annual banquet.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

ERPIDINE
PARGYLINE
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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
No. 6812
ENDURON®
METHYCLO-
THIAZIDE
5 mg

Excellent day-long Na⁺ output, yet easy on the K⁺

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness

Of course, as with all thiazides, supplemental dietary potassiur should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample ir most cases.

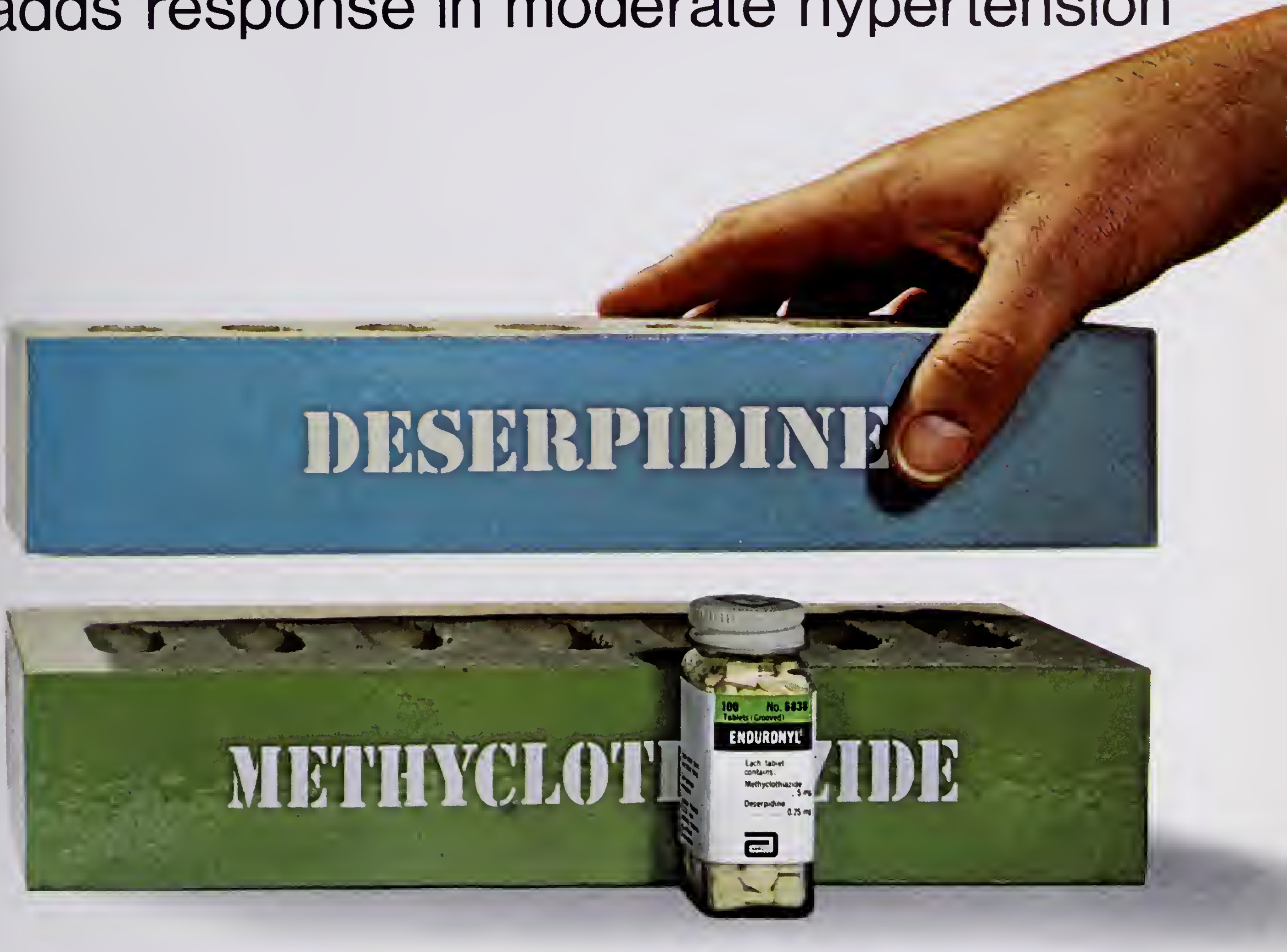
Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension


DESERPIDINE
METHYCLOTHIAZIDE
100 No. 6835
Tablets (Grooved)
ENDURONYL
Each tablet contains:
Methyclothiazide 5 mg
Deserpidine 0.25 mg

Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

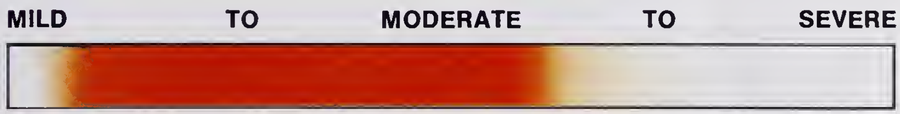
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

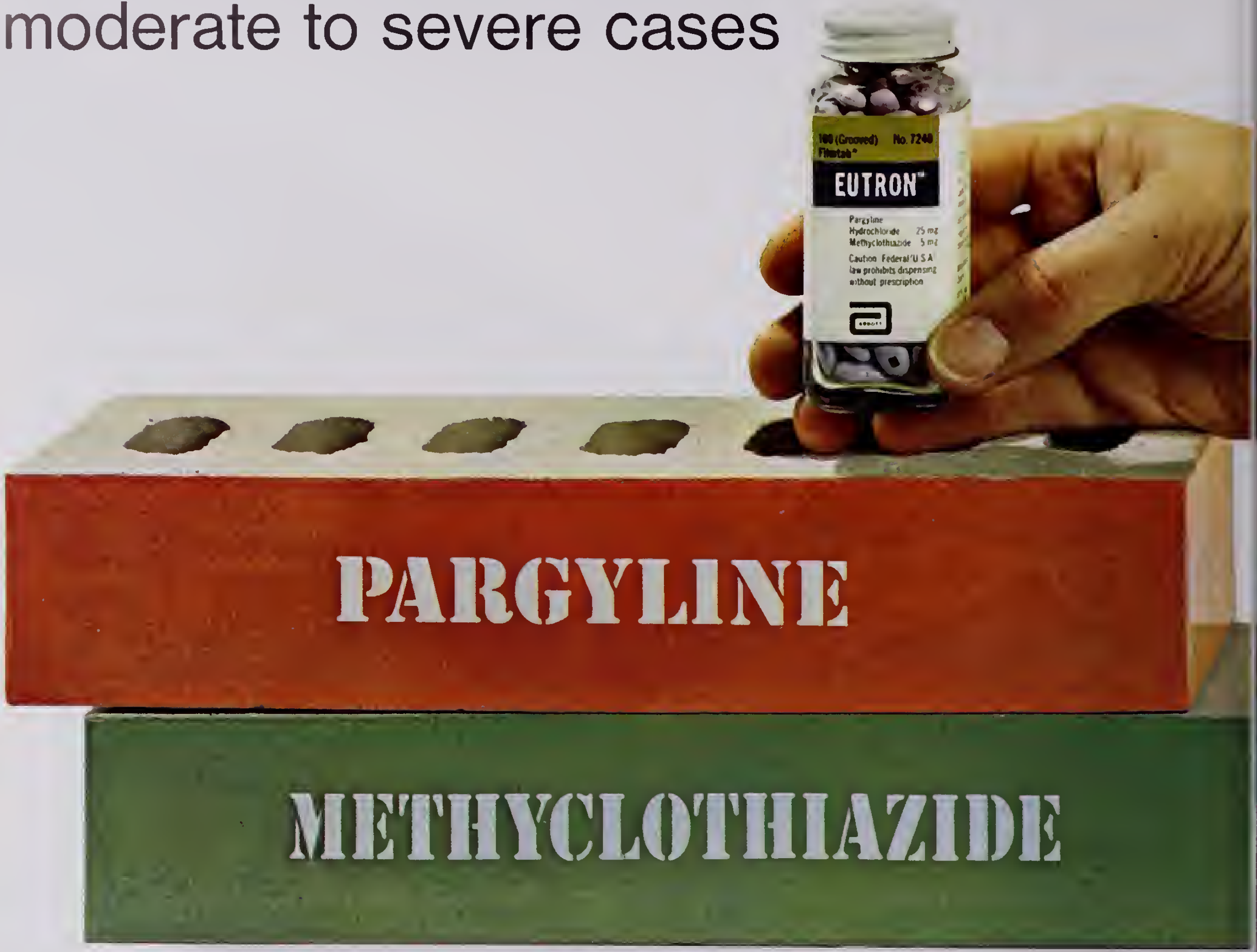
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.


MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON®
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal/U.S.A. law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON®

METHYCLOTHIAZIDE

ENDURONYL®

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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COMING EVENTS

COLLER-PENBERTHY-THIRLBY EVENT SET AT TRAVERSE IN JULY

All Michigan physicians are invited to participate in the 48th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 25-26.

The excellent program will begin at 9:00 a.m., July 25 and conclude at noon, July 26, according to James W. Hall, M.D., local chairman of the committee on arrangements. He reports that the "fine program has been prepared by A. James French, M.D., University of Michigan Medical School, and his associates."

Michigan physicians who have been selected to speak include Alexander J. Walt, M.D., Clifford D. Benson, M.D., G. Thomas McKean, M.D., T. N. Evans, M.D., all of Detroit; William D. Robinson, M.D., Harold A. Oberman, M.D., Edgar A. Kahn, M.D., Walter P. Work, M.D., Stuart M. Finch, M.D., William J. Oliver, M.D., Arthur C. Curtis, M.D., F. Bruce Fralick, M.D., Robert B. Sweet, M.D., all of Ann Arbor; Allen J. Enelow, M.D., Scott N. Swisher, M.D., both of East Lansing; and Warren W. Cline, M.D., Traverse City.

Out-of-state medical educators will come from California, Ohio, Florida, Missouri, Maryland, Nebraska, Minnesota, Texas, and Illinois.

Further details will appear in future issues of *Michigan Medicine.* ☐

Offer Career Guide

MSMS has inserted eight pages of Michigan information in a new AMA "Horizons Unlimited" career pocketbook for distribution to school counselors, libraries, youth-serving agencies and others who guide and counsel young people. The booklet describes the "Challenge of Medicine" and suggests that there are "vast new medical horizons opening up as the result of promising experiments in transplantations." The booklet is distributed by the MSMS Public Relations Committee. Interested MSMS members may obtain a copy of the booklet for reference use in their reception rooms by writing to MSMS, 120 West Saginaw, East Lansing, 48823.

MICHIGAN MEDISCENE

June 5 — The Council, MSMS Headquarters, East Lansing
June 16-20 — 1968 AMA Annual Convention, San Francisco
June 21-22 — Michigan Orthopaedic Society Annual Summer Meeting, Hidden Valley, Gaylord
July 18-20 — The Council, MSMS Headquarters, East Lansing
July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs
Aug. 21 — The Council, MSMS Headquarters, East Lansing
Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit
Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit
Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit
Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor
Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron
Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

OFFER NUCLEAR RADIATION DETECTION COURSE AT U-M

An intensive two-week course in Nuclear Rediation Detection for Medical and Health Scientists will be offered for the first time July 8-19 by the University of Michigan College of Engineering. The introductory lecture and laboratory course is designed to provide a working familiarity with devices and techniques used in the measurement of ionizing radiation. Emphasis is placed on the fundamental principles of detector devices, with examples of their application in radiological health, nuclear medicine, radiology, and related fields.

Further information may be obtained by writing to: Engineering Summer Conferences, Chrysler Center, North Campus, The University of Michigan, Ann Arbor 48105. ☐

MSU Museum Seeks Medical Books, Items

Val Barryman, curator of historical artifacts at the Michigan State University Museum, announced recently that the museum is interested in expanding its collection of medical items.

"We are especially interested," Mr. Barryman said, "in medical instruments, medical books and journals, and doctor's personal records, diaries, or photographs prior to 1930."

Physicians who would like to donate such items can write to Mr. Barryman at the Michigan State Museum in East Lansing. ☐

Is it depression?

She says "I'm always on edge..."

...but her other symptoms: depressed mood, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl

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Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

ACTIVITIES, PROJECTS

MSMS CANCER COMMITTEE URGES PAP TEST

The MSMS Cancer Committee continues to urge women to have a Pap Test to help reduce the predicted 300 deaths in Michigan from Cervical Cancer.

The Cancer Committee, which estimates that only 18 per cent of the adult women in Michigan have ever had a Pap Test, recently pushed the campaign through the Michigan press. A MSMS News Release was carried by many papers. The following headlines, tipical of many, carried the MSMS message:

Grand Haven Tribune: *"Women Reminded Cancer Tests Needed Yearly"*

Utica Daily Sentinel: *"Simple Pap Cancer Test Prevents Many Needless Deaths of Women"*

Greenville Daily News: *"Women Urged to Get Pap Test"*

Escanaba Daily Press: *"Women Neglecting Cancer Protection"*

Petoskey News-Review: *"Women Must Become Aware of Pap Tests"*

MSMS Health Award Honors State PTA

The Michigan Congress of Parents and Teachers (PTA) recently received an Outstanding Health Service Award from MSMS at the state PTA convention in Battle Creek on the occasion of the organization's 50th Anniversary.

The MSMS citation to the PTA was "for distinguished leadership in Michigan during 50 years of service in helping parents and children study and adopt good health practices," and especially "for current PTA programming in such critical health areas as family life and sex education, smoking and health, and others." The award, presented by George W. Slagle, M.D., Battle Creek, also "pledged the continuing cooperation of Michigan doctors of medicine as consultants and program participants during the next half century in the PTA voluntary approach to further improve the family, school, and community."

Recommended by The MSMS Award Committee, the citation was approved by The MSMS Council.

Left to right, Rep. Warren N. Goemaere, of Roseville, Herbert A. Raskin, M.D., Chairman of MSMS Committee on Alcoholism and Drug Dependence, and Rep. Dale Warner of Eaton Rapids, discuss narcotics legislation pending in the State Capitol. Both State Representatives are members of committees dealing with alcoholism or narcotics and Mr. Warner chairs a special study group in this area.

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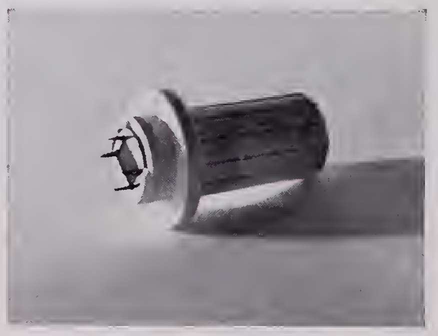

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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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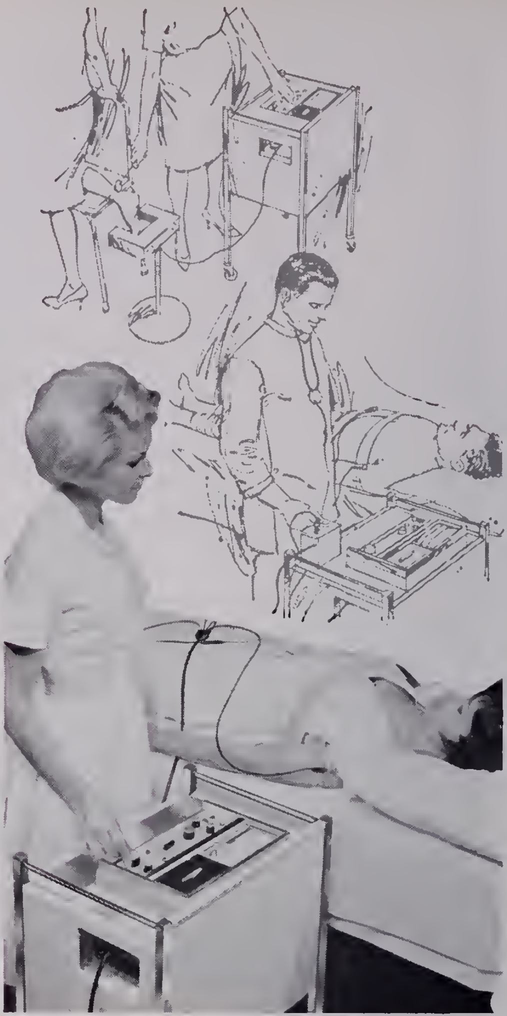

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VIEWPOINTS

Thank You, George; Best Wishes, John

BY BROOKER L. MASTERS, M.D., CHAIRMAN, MSMS PUBLICATION COMMITTEE

This issue of *Michigan Medicine* really has two Scientific Editors as George H. Lowrey, M.D., leaves the post and John W. Moses, M.D., begins his service.

The MSMS Council, at its last meeting, unanimously passed a motion to thank Doctor Lowrey for his outstanding service as the Scientific Editor since April, 1966. He had submitted his resignation because of new responsibilities at the University of Michigan Medical School.

Doctor Lowrey, during his term, provided fine scientific papers for the MSMS membership. Many of these he actively recruited by encouraging physicians to especially develop original scientific articles for *Michigan Medicine*. As a professor of pediatrics at Ann Arbor, he had many contacts with the medical educators; and he had many relationships across the state with practicing physicians through his lectures to county medical societies and hospital staffs.

□ □

The new editor, Doctor Moses is director of medical education at Mt. Carmel Hospital in Detroit and well qualified to serve as the Scientific Editor. He received his medical degree from Boston University and has practiced in Michigan since 1954. He was in private practice until joining Mt. Carmel several years ago.

LOWREY

MOSES

Doctor Moses is an associate editor of the *Detroit Medical News* and has written for many medical publications. He is very active in the Wayne County Medical Society and is one of the WCMS delegates to the MSMS House of Delegates.

The Publication Committee, and The Council, sincerely thank Doctor Lowrey for his contributions to medical postgraduate education in Michigan, and also wish Doctor Moses well as he continues to improve the quality of the scientific articles in *Michigan Medicine*.

The Constant Search

BY MILTON ROUSE, M.D.
AMA PRESIDENT

In all fields of endeavor, there is a never-ending look for new and better ways to nourish man's progress and kindle his hopes for a more perfect existence.

But perhaps nowhere is this endless search more passionate and more meticulously checked and rechecked than in medical science.

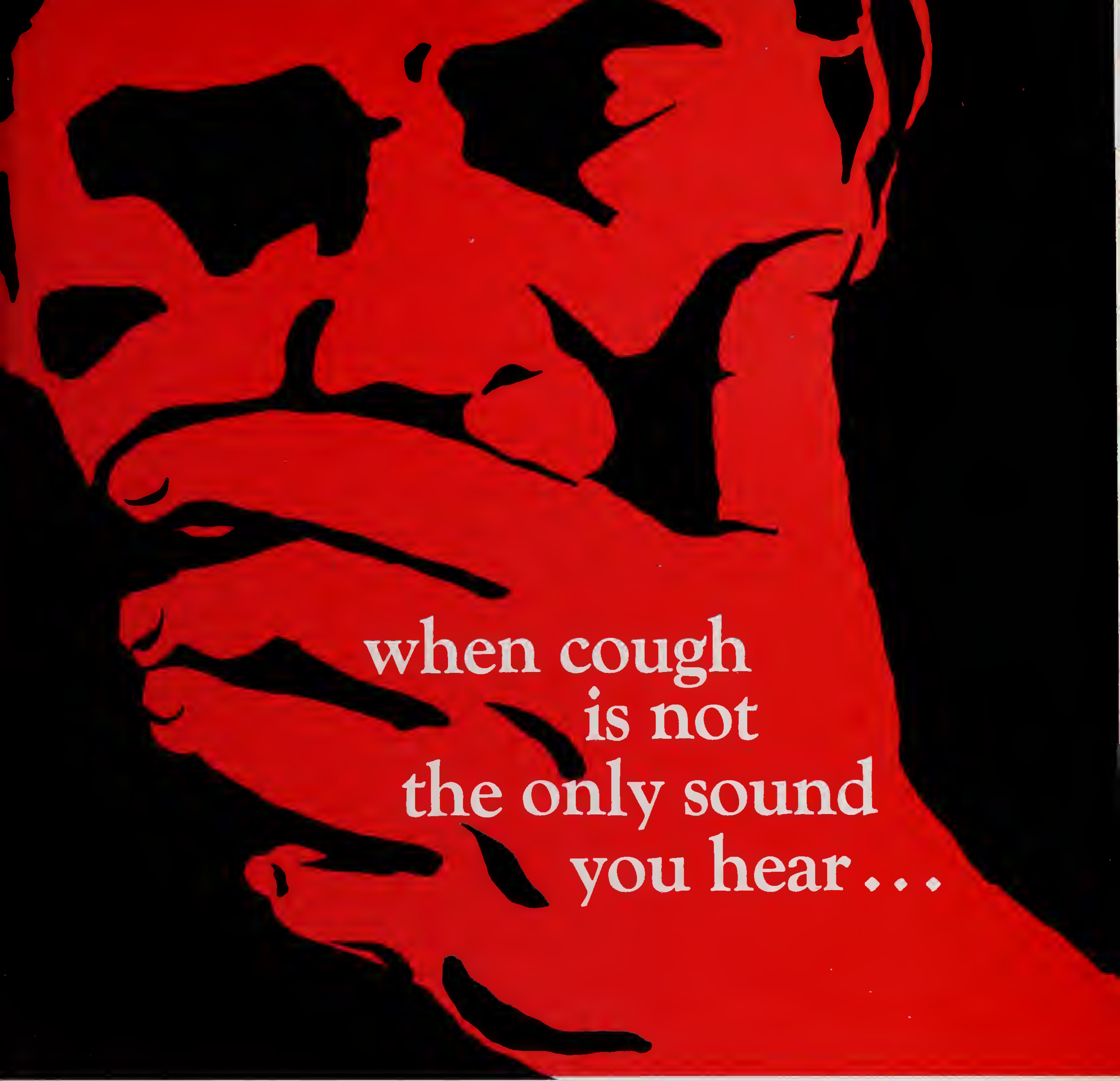
And nowhere are the bounteous fruits of this quest more evident than at the AMA Annual and Clinical Conventions, remarkable scientific spectacles without equal and a living tribute to all who have made personal contributions and sacrifices aimed at furthering the art and science of medicine.

Take the forthcoming 117th Annual Convention in San Francisco June 16-20, for example. This vast panorama of all that is current in every area of medicine will beckon more than 60,000 persons, all of whom will be drawn closer to the heartbeat of medicine and its eternal promise just by being a part of it.

At least 16,000 of them will be physicians taking advantage of a remarkable educational opportunity which will enable them collectively and individually to learn and implement proven methods and techniques destined to further improve the quality of medical care not only for Americans, but for people everywhere.

Indicative of the quality, scope and thoroughness of the Scientific Program in which they will participate is the fact that more than 2,000 men

(Continued on 767)



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'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Class 1 — PHYSICIANS — No surgery.

Class 2 — PHYSICIANS — Minor surgery or assisting in major surgery on own patients.

Class 3 — SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class 4 — SURGEONS — Specialists.

Class 5 — SURGEONS — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

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Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

A different salicylate structure—
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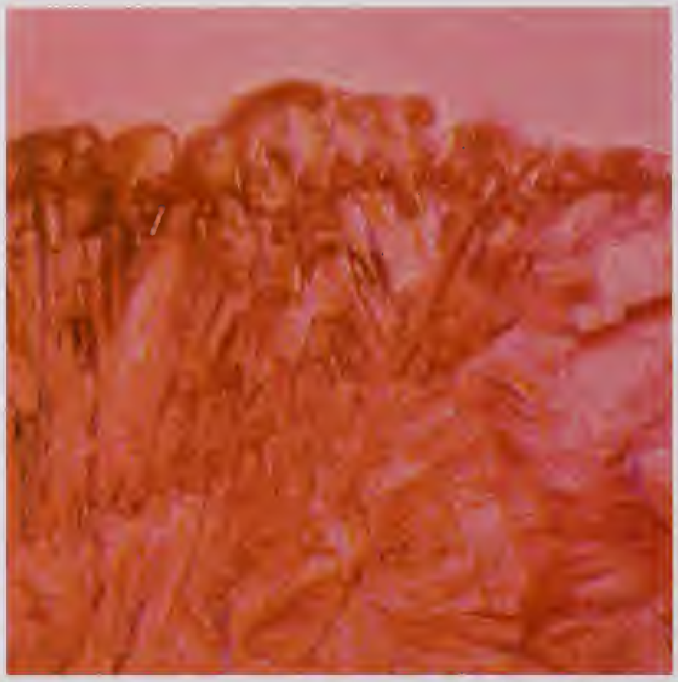
microphotograph of magnesium salicylate crystals



Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

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and women of eminence, of whom the overwhelming majority are physicians, will be presenting it.

Under the astute direction of the AMA's Council on Scientific Assembly, they have amassed the most timely and productive program possible. Its all-inclusiveness guarantees that it will contain subject matter beneficial to every physician, no matter what his area of medical practice or interest.

Among the highlights of the Scientific Program will be discussions, symposia, lectures, panels, exhibits, research reports, color television, and medical motion pictures — all featuring carefully studied, selective topics designed to spur continued learning among all participating physicians, particularly in those areas of greatest medical concern.

There will be more than 253 Scientific Exhibits, and physicians will have the opportunity to view 12 current medical motion pictures. Medical television again will be offered through the cooperation of Smith, Kline and French Laboratories.

Established in 1915 to supervise and coordinate the activities of the various Sections of the Scientific Assembly, the Council on Scientific Assembly has been persistent in its search to arrange the most effective Postgraduate Medical Education Program possible each year.

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Michigan Medicine invites the assistance of MSMS members to help show the advertisers that they are wise in selecting the MSMS journal.

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Few members, we suspect, ever write a note of appreciation to an advertiser even though the reader may be fully aware of the support by the ethical firms.

The Publication Committee does formally express its sincere thanks several times a year through various ways. The Publication Committee also would hope that MSMS members would mention *Michigan Medicine* when visiting with detail men or when writing for complimentary products offered by the advertisers in the MSMS journal. Firms often use mail and coupon-returns as a measurement in placing future ads.

An unsolicited note of thanks, commendation, or even constructive criticism from Michigan doctors can be the greatest return for any advertisement published. Our advertisers would like to hear from you! BLM

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelistu: Clinical Medicine, April 1966.

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Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

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Each orange tablet contains:

Methyl Testosterone	12.5 mg.
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Thiamine HCL	10 mg.

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Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen — only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**. One tablet t i d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**. See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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She can expect to continue Oracon for years

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16 White—Ethinyl Estradiol, 0.1 mg. Tablets; 5 Pink—Dimethisterone, 25 mg., and Ethinyl Estradiol, 0.1 mg. Tablets

Only 4.4% of patients taking Oracon discontinued it because of side effects

Oracon in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue Oracon comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of Oracon, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing Oracon

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of Oracon in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with Oracon. Therefore, if such tests are abnormal in a patient taking Oracon, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. Oracon should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Oracon therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Oracon therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, Oracon should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Oracon may mask the onset of the climacteric. The pathologist should be advised of Oracon therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

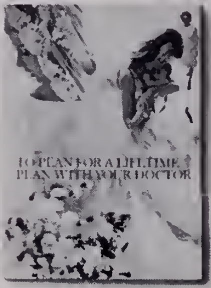
observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.



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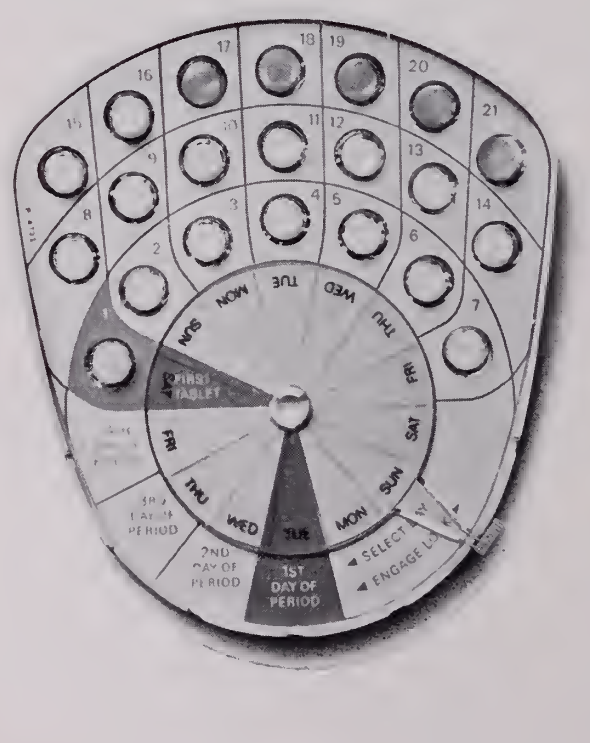

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The Need for Utilization Review

BY LOUIS F. HAYES, M.D.
VICE PRESIDENT
MEDICAL AFFAIRS DIVISION
MICHIGAN MEDICAL SERVICE

"What is Utilization Review?"

The objective of this article will be to provide a simple definition of utilization review. I hope we can make it more explicit than one definition given: "a word of French and Latin derivation, containing 11 letters, whose use in medical circles often causes a vulgar Anglo-Saxon response"; yet I do not want to be as vague as another definition: "striving to reach a goal as yet undescribed, using methods as yet undefined and involving all concerned parties in roles as yet undetermined."

Let's begin with the basic definition of each of these two words. Utilization is "the act of making use of"; review is "to look at again — to look back on — to take a retrospective view." Now let us take a small liberty with these definitions by expanding them a bit to encompass medical services. To do this we need only to add the word "good"; thus our end result is "looking back at making good use of."

To utilize (there's that word again) this definition in terms of health care, we should ask ourselves three questions:

1. What do we look back at?
2. What does it mean?
3. What can we do with the information?

What do we look back at?

To measure utilization of medical services we need only concern ourselves with incidence of services. Tabulation of the frequency of items of all kinds, hospital days, surgical procedures, diagnostic procedures, office and home visits would provide an impressive array of statistics. Another dimension should then be added — patient information, such as age, sex, location and diagnosis. Such items then become the raw material for utilization review.

What does it mean?

Establishing relationships between the above mentioned items would give us patterns of use by environment, profiles of practice by providers and utilization by patient. Interpretation is another matter; the mathematical relationships could be subjected to statistical analysis, but a more significant interpretation requires medical judgment. Only physicians can suggest with relationship, which patterns, which profiles have sufficient medical significance to make them reasonable indicators of medical quantity. And it necessarily follows that only physicians can examine these quantitative factors and draw conclusions relative to the quality of care.

What do we do with the information?

Obviously, information is of little use unless it can be used in a practical manner. Ultimately, utilization statistics should have the function of improving the use of and quality of medical care. To effect this, we delete the word "review" and substitute a more onerous word, "control."

The responsibility for control in the area of quantity belongs to the carrier and the physicians (both inside and outside the carrier structure). When data reveals misuse, the fiscal responsibility of the carrier dictates appropriate action. Detection of over-utilization calls for a joint effort, the carrier in identifying, physicians in correcting.

Control of the quality of medical care is another matter. In this endeavor, the carrier serves

AUTHOR:
HAYES

First in New Series of Articles:

The following article is the first of a series to be prepared for publication in *Michigan Medicine* by the staff of Michigan Medical Service. Future articles will deal with the following topics:

The Need for Utilization Review
Utilization Review Systems-Characteristics and Operation
Measurement of Quality and Quantity of Medical Services
Role of Non-Physician in Utilization Review
Role of Physician in Utilization Review
Michigan Utilization Review Project

primarily an educational function; as the reservoir of raw data and, because of computer capacity, they should be responsible for the preparation of information — they "review." "Control" requires medical judgment and appropriate corrective measures; heavy physician involvement is needed to do this effectively. Since physicians have the right to medical judgment in the quality of medical care, they have also the obligation of correction when poor quality is detected.

The charge will probably be made that I have over-simplified this matter — but I have a compulsion to reduce problems to simple terms. It would seem elemental that the carrier, as the source of data, be responsible for arraying the statistics — and equally fundamental that the physicians are the only ones capable of making judgments on the quality of care. But a more important point is that this should be a mutual endeavor, with divided responsibilities but a common goal — providing the best medical care at the lowest possible cost. □

Health Council, Consumer's Publish Booklet to Help Recruit Doctors to State

The Michigan Health Council, in cooperation with Consumers Power Company of Jackson, is distributing a new brochure designed to attract family physicians to practice medicine in rural areas of Michigan.

The booklet gives large emphasis to the natural beauties of Michigan, the excellent medical facilities in the state and the personal testimony of several Michigan physicians who have found rural practice rewarding.

"I have had more than fifteen years of family practice in a typical small community in Michigan," writes Brooker L. Masters, M.D., of Fremont. "During this time, I have enjoyed a most rewarding professional life, as well as a most desirable community in which to live with my wife and children."

"Not only baby, but parents, grandparents, aunts, and uncles have been an integral part of the mosaic of my life as a family doctor in a small community," says R. W. Spalding, M.D., of Bloomingdale.

"Here, the pace of living has been slow enough to allow time for growing up with my family and, at the same time, be a respected and esteemed member of every other family in the community. A source of great personal satisfaction has been the opportunity to help guide so many lives from babyhood to childhood into the teen years and on through adulthood," Doctor Spalding concludes.

Ten thousand copies of the brochure have been printed and are being distributed throughout the U.S. to physicians who have expressed interest in Michigan as a place to establish practice.

"We also have distributed copies to the medical schools," comments John A. Doherty, Executive Director of the Michigan Health Council. "The booklets will be given to freshmen, sophmore, and junior medical students so that early in their career they will become aware of the great potential in rural medical practice."

Ben N. Saltzman, M.D., A.M.A. Chairman of the Council on Rural Health, also comments in the booklet: "I enjoy knowing people and their families. I like being treated as a member of a family and at the same time held in a position of respect and esteem. My philosophy of life is a simple one—freedom from financial care; good health and adequate educational opportunities for my children; and a position of prestige for my wife and myself in a community. This, in essence, is the recompense for family practice—and what I have enjoyed for 21 years."

"We all enter the field of medicine with personal dedication," Doctor Saltzman concludes. "Through rural family practice in an uncomplicated, straight-forward and appreciative environment, I have realized the fulfillment of those early dreams." □

When it's more than a bad cold

your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

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A booklet describing this program in complete detail has been mailed to all physicians in Michigan. If you did not receive it, or if you have any questions, write Michigan Blue Shield, or contact your local Professional Relations representative.

What Is Current Thrust of MSMS In Areas of National, International Affairs?

Where does MSMS stand regarding national and international affairs?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?"

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS. The November, 1967 issue of *Michigan Medicine*, on pages 1139 to 1143, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Physicians who might have missed any of the previous articles may wish to go back and read them. The following article is Chapter IX in the booklet. Copies are available from MSMS, 120 West Saginaw, East Lansing 48823.

Discussion

International Health

This is perhaps the weakest area of MSMS participation. Only in the past year or so has it had a Committee on International Health.

Need in Vietnam

That committee has determined that there is great need in Vietnam for medical aid, particularly if the United States is to reap any reward for its military action there. It will emphasize international health at the MSMS Annual Session.

MSMS Members Serve

Almost by contrast with MSMS as an organization, its members have been extremely active. Michigan doctors have led the nation in percentage of service contribution to Project HOPE, Partners of the Alliance, South Vietnam service, and as medical missionaries abroad.

Doctor Diplomacy

MSMS Participation in Foreign Affairs

Experts on foreign affairs have repeatedly pointed to the fact that doctors working in foreign countries have created more good will than any other "diplomacy" of this nation. These doctors must come from the private sector if they are to be most effective. MSMS has responsibilities as a member of society and a "corporate citizen" of the United States to participate in foreign affairs, particularly when it is recognized that Michigan business, industry, and transportation are now becoming major factors in foreign trade.

Opportunity for Leadership in AMA

Obviously, in many instances the AMA is the proper organization to work through, but a great opportunity exists in that organization for MSMS to give leadership in this field.

Questions

Michigan Partners of the Alliance Belize

A. What part should MSMS play in the medical care of the people of any foreign nation? Belize, as Michigan Partner in Partners of the Alliance for Progress?

World Peace

B. Does MSMS have any responsibility for maintaining world peace by assisting in developing friendly relations with neighbor nations?

Organized Foreign Medical Assistance

C. Should MSMS take an active role in national and international relationships with such organized efforts as the Partners of the Alliance, Project HOPE ship, AMA international physician placement service, etc.?

Recognition of Service

D. Should MSMS honor, individually, its members who are serving now
    1. In the armed forces?
    2. As medical missionaries?
    3. On the HOPE ship?
    4. In the AMA Viet Nam project?
    5. Etc.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT

CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

FOR THE FOUR-WEEK PERIOD ENDING APRIL 26, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	36	143	157	641
Whooping Cough	54	105	186	385
Diphtheria	0	0	0	0
Mumps	2079	2195	9376	8133
Scarlet Fever & Strep Sore Throat	1006	1451	5104	7071
Tetanus	0	0	1	0
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	149	121	610	746
Salmonellosis (Other than S. typhi)	39	32	205	182
Typhoid Fever (S. typhi)	0	3	0	4
Shigellosis	22	35	71	155
Aseptic Meningitis	2	2	20	6
Encephalitis	3	9	31	33
Meningococcic Meningitis	7	11	37	25
Influenzal Meningitis	5	4	19	13
Tuberculosis	233	261	997	1054
Syphilis	496	435	1912	2047
Gonorrhea	1386	1252	5547	5282

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

An anorectic will help her lose weight–but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

FRONT SIDE

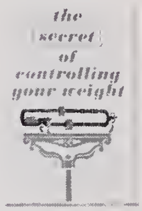
DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

FRONT SIDE

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories. 801444

To
help you
control your
weight...

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
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DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT
801444

Should State Support Osteopathic College?

THIS EDITORIAL APPEARED IN ANN ARBOR NEWS

There is every good reason for the state to proceed slowly with plans to support a college of osteopathic medicine.

Affiliation of an osteopathic institution with one of the state-supported universities is practically a prerequisite, but the schools with established medical colleges don't want an osteopathy program — at least not very badly.

The two disciplines — osteopathy and the traditional MD-granting medicine — barely coexist. But an osteopathic college with state support and university control is a maverick institution supporting itself on dribbles of federal aid, citizen contributions and money from the D.O.'s (Doctors of Osteopathy) themselves.

But with one new medical school (Michigan State University) being funded from scratch and other needs in medicine requiring urgent attention, a $10 million outlay for a college of osteopathic medicine cannot be justified economically.

What kind of prospective medical student is attracted to osteopathy, for example, and how many of this type of student are there out of, say, every 20 medical students? The state just isn't ready, in our estimation, to endow a small and controversial "branch" of medicine with a college of its own. ☐

THREE PHYSICIANS SERVE ON KIEFER CENTER BOARD

John Lumpkin, M.D., from the Detroit Medical Society, A. H. Hirschfeld, M.D., from Wayne County Medical Society, and James J. McClendon, M.D., president of the Detroit Board of Health, will serve on a 15-member board which will direct the Comprehensive Health Services Center, Inc.

Funded by a $2 million Federal grant and located at Herman Kiefer hospital, the health center will serve approximately 33,000 disadvantaged residents in the center of Detroit. Members of the Board of Directors represent various professional health organizations, the Detroit Health Department, the Mayor's Committee for Human Resources Development, and residents of the area to be served by the Health Center. ☐

RECEIVES ENURESIS AWARD

Barbara Starfield, M.D., of Johns Hopkins Hospital, has been named recipient of the 1967 Award of the Enuresis Foundation. James C. Breneman, M.D., Galesburg, president of the Foundation, said the award is presented annually "to the person thought to have contributed significantly to the knowledge and understanding of enuresis and its related afflictions." ☐

Voluntary Associations And the American Society

BY C. T. HARDWICK, Ph.D.
MSMS ECONOMIC CONSULTANT

Nature of Issue

In contemporary American society, we often contrast the private sector versus the public sector. In general everybody knows the government is on one side and free enterprise consisting of business and professions on the other side. Of course, in reality these opposing forces are compelled into cooperative ventures for total action. However, there seems to be a large organized force also present in current America which should be identified as the *voluntary associations.*

These free associations generally belong to the private sector, but for practical reasons a separate identification seems necessary.

Voluntary associations means an *organization of equals* which is composed of members who *join of free will* for common group purposes.

Some writers call these *mutual-benefit* organizations and examples would include professional associations, fraternal groups, unions, trade groups, clubs, veterans' groups, neighborhood groups and religious sects. Often these organizations are popularly called service groups with private and public interests. Often members are rallied around specific "causes." The organizers attempt to verbalize in idealistic terms the objectives and work of the association for the mutual benefit of members and society in general.

Of course the Michigan State Medical Society would be a prime example of a voluntary association. Individuals acting alone feel weak, but when joined together have strength and power.

IT MUST BE NOTED that voluntary associations are founded and also flourish in an open free society such as current days of progressive America. In a free society, it is part of our heritage and a principle of staying free to encourage the voluntary joining together of a few, or several or many citizens to promote or to fight any cause as they see fit, that is, it is natural for independent citizens to join forces as they please to combat or support government or other organized efforts. Obviously, as recorded history proves, the authoritarian or dictatorship can not and does not permit such freedom for voluntary associations. Hitler and Mussolini abolished and prohibited such mutual-benefit associations which would be expected to fight the monolithic government.

To satisfy the urge of their citizens the dictators usually organized "front" or government sponsored organizations to speak for voluntary groups.

Therefore, it seems essential to know and understand better the role of voluntary associations in the American society. We are fortunate that our natural inclination to form independent associations is permitted and even encouraged as a right of free citizens. Furthermore, a deeper understanding may assist in making voluntary associations more effective and constructive in furthering the well-being of a democratic society.

Growth and Organization

At the initial stages, a few enterprising individuals see the need and potentiality of joining forces with their fellow associates in forming a new organization. This leadership group then issues an invitation to a limited membership with the aim to organize a core action group.

Next, some idealistic and general objectives are identified such as educational, promotional, public relations and representative of delineated viewpoint. Then a broadcast for qualified members is issued and an organizing meeting will be called. Officers are elected and a program of action planned for the coming year. More and more members will be attracted and held if some crisis issue can be found and formulated. The cycle of electing officers and planning programs will have to be repeated for ensuing years.

Then the issues will become more critical or the membership will enlarge or the program will grow to ambitious heights and a reorganization will be stimulated. During the early formative years, all officers, leaders and workers will be part-time volunteers without much remuneration for efforts; thus their time, energy and attention will also be limited.

The increasing demands for more active programs require the employment of some full-time staff.

AT THE TIME OF hiring a full-time staff, some new division of labor will be necessary. The hired employees must assume the handling of routine daily business and the "back up" work for leaders and members. However, the voluntary leaders are still responsible for goals, policies, direction and control of organization.

Now the organization is ready for action at the matured stage of development. Old, routine programs will have to be up-graded; new programs launched and activities enlarged on a broader front.

Leadership and staff will have to analyze programs to determine which ones are merely routine and defensive. With the help of full-time staff, more programs of a constructive, positive and aggressive nature will have to be organized and supported.

In other words, programs will be conducted on two levels. For the short run, some practical service programs should be organized so as to involve as many solid members as practicable.

FOR THE LONG run, some bold and free-wheeling programs are desirable to influence the future direction of the association. These latter programs should be attractive to the younger and avant-garde members.

Since the financial resources of voluntary associations are very limited, usually membership dues are inadequate to support unlimited activities. Thus, each year the activities of staff, committees and programs have to be reviewed and evaluated as to annual contributions. A strict budgetary process will help at this stage of appraisal.

Critical Issues for Associations

In a free society, voluntary associations have strong reasons for growth and survival. As long as leaders and members have purposes and programs satisfying their personal and professional needs, the voluntary association will grow and prosper until government or social forces mount an offensive against them. The attack by government is not expected as long as free enterprise is popular.

THE QUESTION OF "other social forces" will be a challenge to every voluntary association. Unless the association satisfies members, other associations may be formed in a dynamic society. Therefore, independent associations have to be sensitive to readjustments in order to meet changing social needs. Generally voluntary associations have to meet selfish demands of members and still serve the general public.

The voluntary associations prosper on two fronts: namely, routine services to members and the handling of a crisis situation.

Repeated crises tend to solidify membership and leadership has a special problem of keeping up interest with members during ordinary and dull periods. Thus, the leaders have to develop foresight and stimulate interest in future issues. Every year the programs have to have some focus on critical issues to hold and attract interest and attention.

The acid test of the voluntary association in modern America will be settled at the local meeting centered on the questions:

(a) *Do we have a special purpose for existence?*

(b) *Is our organization the best means for accomplishing these purposes?*

In conclusion, the future for voluntary associations in America looks very bright and prosperous as long as we can answer a very strong *yes* to both of the foregoing questions. Therefore, the leadership group has to take immediate steps to keep their organizations alert to their responsibilities and opportunities to contribute constructively to the growth of our free society. If the independent organizations do not respond to this challenge, we have only ourselves to blame.

AUTHOR

Doctor Hardwick is Economic Consultant to the Michigan State Medical Society and Associate Dean, school of business, University of Detroit.

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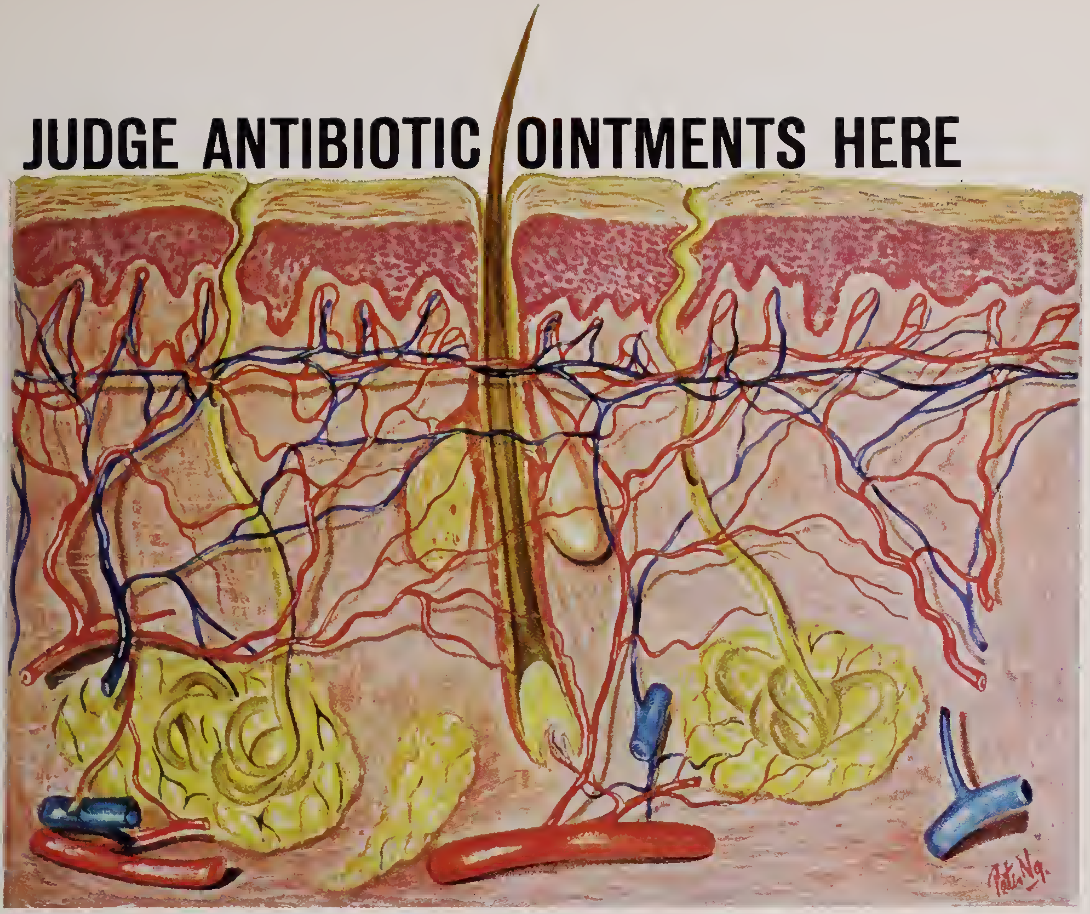

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Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent
laboratory and clinical evaluations. Should this trend continue, the dr
should be discontinued.
2. Liver function tests must be performed at regular intervals during t
ment with this drug since liver damage may occur during therapy. The
drug should be discontinued immediately in cases of aggravated liver
dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonc
etry, are recommended for patients being treated with this drug since
many phenothiazines and related drugs have been shown to cause ey
changes.
4. Complete urinalysis and BUN should be done on patients treated
Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet,
nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto
eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities i
liver function tests, cholestatic and hepatocellular jaundice, urinary fre
quency, acute urinary retention, oliguria with elevated blood pressure,
albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri
impotence, disturbances of coordination, confusion, headache, fatigue
blurred vision, transient diplopia and oculomotor disturbances, speech
disturbances, abnormal involuntary movements, peripheral neuritis an
paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency,
pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom
photosensitivity reactions, alterations in skin pigmentation, exfoliative
dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryt
multiforme and nodosum, aggravation of disseminated lupus erythema
tosus, gastric distress, abdominal pain, diarrhea, constipation, anorex
dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills,
adenopathy, lymphadenopathy, aching joints and muscles, leg cramps
conjunctivitis, left ventricular failure, aggravation of hypertension, hyp
tension, syncope and collapse, edema, aggravation of coronary artery
disease and congestive heart failure. (Whether these cardiovascular e
are drug-related is not known. However, some of these complications
resulted in fatalities.) The necessity for discontinuing the drug should
dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with mea
if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the d
should be increased in one-half tablet (100 mg.) increments every 12 h
until freedom from pain is achieved. To relieve pain, between 200 mg.
1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients
with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range
between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should
made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000.
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For complete details, please see Prescribing Information.

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when you want to prescribe therapy that is generally well tolerated. (However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. (One tablet a day usually costs about a dime.)

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

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Blue Shield Reports On Participation, Other Current Programs

BY MICHIGAN BLUE SHIELD

The Michigan Blue Shield report to The MSMS Council in April highlighted a number of topics of continuing mutual interest, of which the Participation Program remains of concern.

Participation Program

While participation agreements are increasing overall in every category, this five-month old program reveals definite trends which, although encouraging, are by no means entirely satisfactory. (See chart below).

Blue Shield's goal is 80% participation by the end of 1968.

In terms of specialty reaction to the Variable Fee Program on the part of doctors of medicine, a breakdown of current participation by generalist-specialist categories is revealing.

Current Physician Participation by Categories

81%	Pathology
81%	Pulmonary disease
81%	Preventative medicine
78%	General Practice
74%	Physical medicine and rehabilitation
72%	Radiology
70%	Dermatology
64%	Cardiovascular disease
59%	Ophthalmology
57%	Neurology
56%	General surgery
55%	Internal medicine
55%	Psychiatry
54%	Otorhinolaryngology
53%	Gastroenterology
51%	Unknown
50%	Allergy
50%	Drthopedic surgery
47%	Obstetrics and gynecology
44%	Neurological surgery
39%	Urology
36%	Anesthesiology
36%	Thoracic surgery
28%	Proctology
18%	Plastic surgery

The participation agreement constitutes the primary, tangible difference between Blue Shield and the insurance companies. Historically, because of its special relationship with the medical profession, the concept of "service benefits" has been a unique quality with respect to Blue Shield. Formal participation, which underlies the whole concept of "service benefits," is necessary if the Variable Fee Program is to maintain Blue Shield superiority.

Variable Fee Administration

Blue Shield has made a number of studies of physicians' fees based on the customary charges reported for Medicare patients and is now engaged in a broader study of the costs of medical care in Michigan.

Since February, 1967, accumulated data involving current charge patterns for a 12-month period have been processed by computer in three separate studies. These studies are insufficient for drawing any final conclusions.

When statistics from a 2-year experience are available, in February, 1969, conclusive studies will be made.

Utilization Review Research Project

This project has moved into an operational phase and is now fully staffed. The Utilization Review Medical Advisory Committee has made suggestions for patterns, profiles and special projects and three important activities are now under way:

1. PILOT STUDY, to determine the feasibility of accumulating a research tape on a subscriber or user basis, and to estimate costs of undertaking a demographic survey for addition to this tape;

2. RESEARCH TAPE, to build which both analysis and programming are now in progress;

3. HISTORY TAPE, featuring selected data being extracted from computer tape files dating from 1959 to 1967. This data will serve as a source of information for reports on past profiles and patterns and will provide a basis of comparison for future studies.

New DSR and Plastic Identification Cards

Blue Shield's claims handling volume is expected to increase from the present level of six million claims annually to more than thirty million within a few years. Among steps taken to prepare for this growth, the new Doctor's Service Report and development of an all-new plastic ID card are expected to simplify both reporting of claims and claims processing.

The new DSR, which will be distributed in

Category	Percentage of Participation December, 1967	April, 1968	Participation Totals	Total Doctors of Record April, 1968
M.D.	60.6%	63.0%	4757	7587
D.O.	44.0%	71.0%	1267	1790
D.S.C.	12.0%	73.0%	188	258
Total	56.4%	63.9%	6212	9635

June, eliminates the need for the patient's signature and involves reporting by code only. The embossed, plastic ID card for imprinter use, which will be introduced early in 1969, will make it possible to transfer all pertinent subscriber information directly to the reporting form. A separate report on this will be furnished to *Michigan Medicine* before implementation.

Both projects should greatly reduce the possibility of transposition errors on the reporting form and help to speed claims processing. ☐

Taxes Taking More And More of Person's Income in Michigan

BY ELMER WHITE
EXECUTIVE SECRETARY
MICHIGAN PRESS ASSOCIATION

Revenue from state and local taxes increased 96% over the decade 1957-67, the Michigan Department of Revenue reports. Over the same period, personal income reflected only a 67% increase in additional dollars.

Tax dollars collected from local property taxes increased 82%, but local income taxes levied by six Michigan cities pushed the figure to 92% over 1957 tax revenues.

State taxes show an even greater increase: 99% more revenue is flowing into Lansing from state-levied taxes than 10 years ago. Federal taxes from Michigan residents are bringing in about 65% more revenue than in 1957.

Each tax dollar is now divided into 79.29c for the Federal government, 11.52c for the state and 9.19c for local governments.

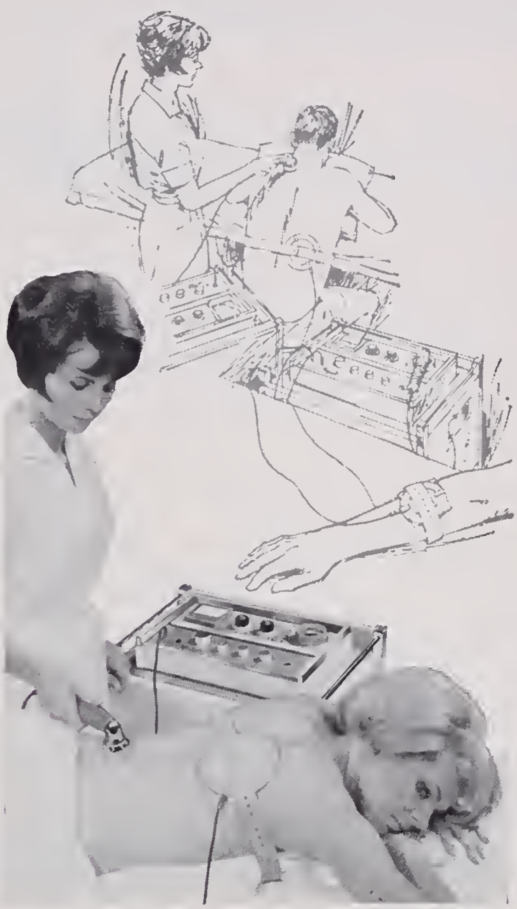
No matter how one views the figures, the conclusion is the same: taxes are taking a larger percentage from personal income every year. To the taxpayer it may make little difference which units of government get the spoils. He is left with fewer dollars to spend.

Yet, unless demands for government services decrease, it is doubtful that the trend to higher taxes will reverse itself.

(Editor's Note: This article appeared in a recent "Michigan Mirror" column written by Mr. White for Michigan newspapers) ☐

REPRINTS DISTRIBUTED OF UCER ARTICLE

Sandoz Company ordered 19,000 reprints of the article by Erol Ucer, M.D., Lapeer, on "Chlorpromazine and Thioridazine In Severe Mental Deficiency," which appeared in the March, 1968 issue of *Michigan Medicine*. ☐



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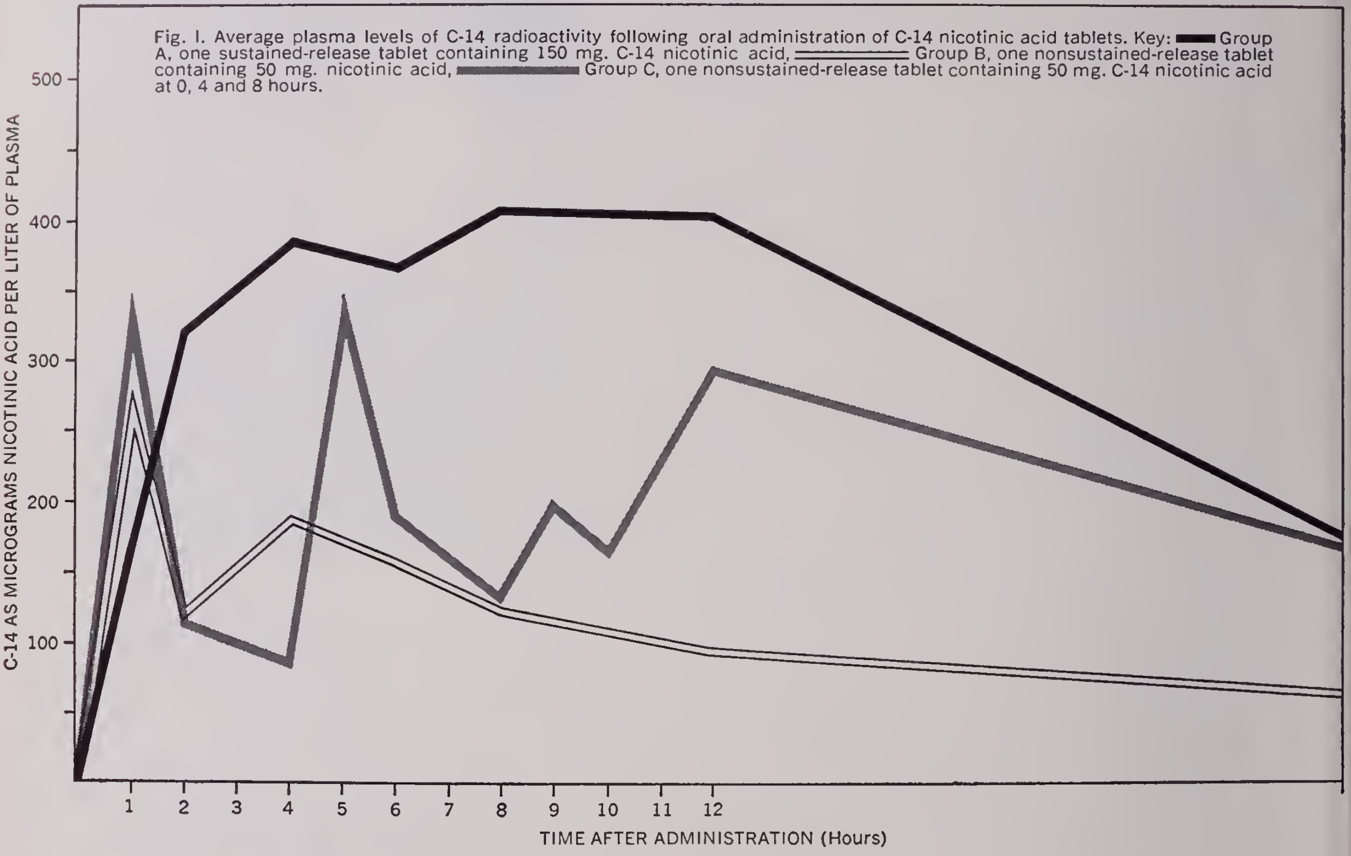

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert

ged and debilitated

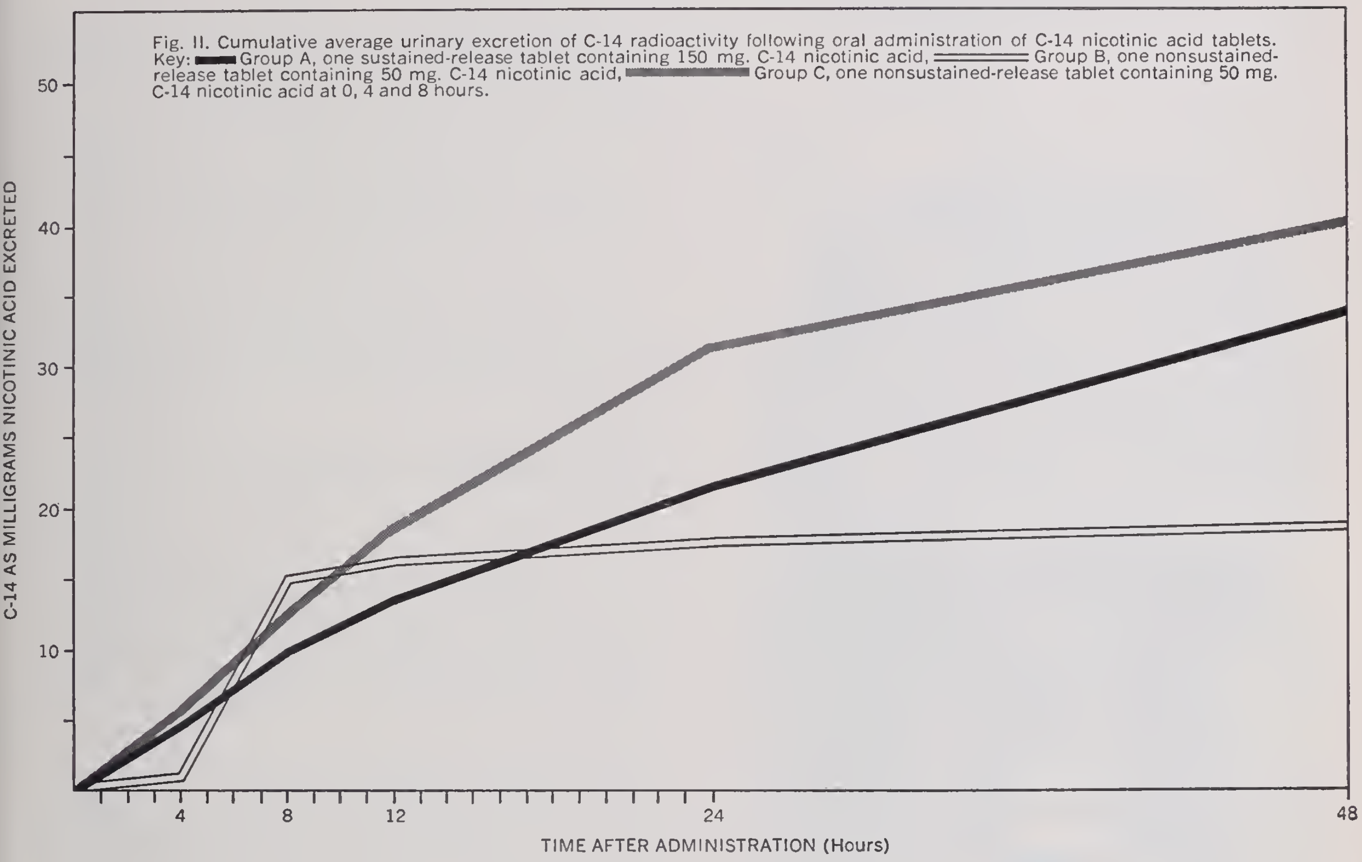

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Work of Detroit Youth Commission in Health Is Explained

BY PETER HOHEISEL
OF THE MSMS STAFF

Several physicians are serving with the Detroit Commission on Children and Youth in several areas of activity with medical implications.

Among the members of the Commission, which is an agency of the City of Detroit and a cooperative agency with United Community Services, is Peter Beckett, M.D., of Lafayette Clinic.

Serving on the Advisory Committee is John J. Hanlon, M.D., Detroit Department of Health Commissioner. Both the Mental Health Committee and the Physical Health Committee have several physician members.

MENTAL HEALTH COMMITTEE

The Mental Health Committee is chaired by Richard Komisaruk, M.D., Director of the Clinic for Child Study. Other members are Lawrence E. Jackson, M.D., Director of the Children's Emergency Psychiatric Clinic at Herman Kiefer Hospital, Peter Beckett, M.D., Sander Breiner, M.D., Thomas A. Petty, M.D., and Lawrence P. Tourkow, M.D.

One of the activities was to work for the establishment of an emergency psychiatric clinic for children at Herman Kiefer Hospital. Financed initially by a $300,000 grant from the city and from United Community Services, the Clinic now is funded by the city and state. It has inpatient facilities for 20 youngsters, and provides several other services including a day care program and outpatient psychiatric care.

In the area of legislation, the committee, in conjunction with the State Department of Social Services, has recommended that the child abuse reporting law be amended in several ways. Among them are:

a) Eliminate the requirement for medical examination in the reporting of suspected cases of abuse.

b) Expand the function of the State Department of Social Services to include the responsibility for arranging a mandatory medical examination as part of its investigation in each case of suspected abuse reported to it, regardless of the extent of injury.

c) The physician's report be separated from the form on which the suspected abuse is reported and that it only contain an objective description of the child's condition and injuries.

d) Reword the law so that a non-medical person who initially observes the abuse is more clearly afforded identical immunity to that of the physician.

e) Provide the State Department of Social Services with the authority to assume payment for medical examination in such cases when the examination is arranged for by the Department and when the examination is secured by the observer, but the parents are unable to pay for it.

In cooperation with UCS, the committee published a fact sheet for reporting actual or suspected cases of child abuse in Detroit and Wayne County.

At present the Mental Health Committee is working to make the child abuse reporting law more effective.

Another project was to gather statistics on the incidence of suicide and suicide attempts by young people.

PHYSICAL HEALTH COMMITTEE

The Physical Health Committee has been especially active in the field of recruiting young people into health careers and up-grading sex education courses in schools.

Serving on the committee are C. Dale Barrett, M.D., Executive Director of PRECAD, and Margaret Zolliker, M.D., Director of the Maternal and Child Health at Herman Kiefer Hospital.

This past spring, about 200 selected students from Detroit public and parochial schools took part in a "Health Careers for Youth" program at Mercy College. They toured the Health Careers Mobile, heard Louis F. Hayes, M.D., discuss career opportunities, watched the new AMA film "Horizons Unlimited," and talked with counsellors about the field of health careers.

In the field of sex education, the Physical Health Committee was active in establishing the Detroit Sex Education and Information Council. Richard Komisarvk, M.D., Calier Worrell, M.D., and Everal Wakeman, M.D., are members of this Council and taking an active role in community education and in exchange of materials pertinent to sex education.

The committee has also been concerned about revising the Michigan sex education law.

Roberta Hughes is the executive director of the Detroit Commission on Children and Youth.

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MSMS Seeks To Improve Performance Of Medical Assistants

BY PHYLLIS MARQUARDT, CMA, KALAMAZOO; CHAIRMAN, MSMAS PUBLIC RELATIONS

"Education is the knowledge of how to use the whole of oneself. Many men use but one or two faculties out of the score with which they are endowed. A man is educated who knows how to make a tool of every faculty—how to open it, how to keep it sharp, and how to apply it to all practical purposes." —*H. W. Beecher*

One of the most important objectives of the Michigan State Medical Assistants Society is to "render educational services for self-improvement to its members."

In turn this improvement is reflected to their employers by their increased value to him. Because of this many doctors not only urge their medical assistants to become active in the group, but subsidize the membership for their employees. What is practically impossible to accomplish individually can be accomplished by pooling the thinking of many. It is the same with the American Association of Medical Assistants.

It has been said many times that the only real justification for an organization such as MSMAS and AAMA is improvement in the medical assistants' performance on the job.

SINCE MSMAS WAS organized (1949) each county chapter has had its education chairman who arranged special programs, both formal and informal, in which the members could participate. Speakers at the monthly meetings are chosen for the scientific and educational stimulus they can bring to the members. The exchange of ideas and suggestions among the members is also a part of the educational program. All of these ideas are as important today as they were when we felt the need for an organization such as ours. However, as the practice of medicine becomes more and more specialized and more physicians are forming "group practice," the educational needs of the medical assistant could not be met in these ways alone.

MSMAS was a forerunner in preparing an in-service training program with the cooperation of the Michigan State Medical Society and the Extension Service of the University of Michigan. With additional help, in the form of a grant, from the W. K. Kellogg Foundation six syllibi were prepared as a guide for the formal classroom study through adult education classes. These syllibi are still being used by many of our county chapters, although the course material needs revision to meet the present educational requirements of the members. It is the hope of the MSMAS Education Committee that this revision will be accomplished this year.

IN 1959, ONLY three years after the birth of AAMA, at the insistance of medical assistants all over the country, the AAMA House of Delegates approved the appointment of a special committee to develop a Certification Program. Presently serving on the Certifying Board are three physicians, three educators, six medical assistants (all CMA's), the AAMA president and president-elect, plus an additional medical assistant who serves as the chairman. The goals for this program are as follows:

1. To help physicians identify those qualified as top-level office assistants, administrative and clinical.

2. To establish professional standards and goals for medical assistants.

3. To assist schools and colleges in developing training programs for medical assistants.

4. To prepare and administer an annual examination.

5. To certify those who successfully complete the examination.

Certification is not required for membership in MSMAS or AAMA, but it is an opportunity for the medical assistant to voluntarily upgrade her position. It is not a requirement for holding or obtaining a job as a medical assistant, and, further, it is not an attempt to evaluate her performance on her present job.

The examination is divided into seven sections. All candidates must pass the first three sections of the examination which are:

1. Medical terminology, anatomy and physiology.

2. Personal adjustment and human relations; medical ethics and etiquette.

3. Medical law and economics.

For the Administrative Certificate the candidate must also pass sections 4 and 5 covering:

4. Office skills and procedures; accounting, credits and collections.

5. Written and oral communications; records, medical and non-medical.

The candidates for the Clinical Certificate must pass, in addition to the first three sections, section 6 and 7:

6. Examination room techniques, sterilization procedures and care of equipment.

7. Laboratory orientation.

IN ORDER TO BE eligible for certification testing the applicant must be at least 21 years of age at the time of application, be a high school graduate or sumbit equivalency certificate, have a minimum total of three years employment by a Doctor of Medicine in an office, hospital or clinic, have at least twelve months continuous employment with one Doctor of Medicine, hospital or clinic, and the application must be signed by the current or most recent employer. (Membership in AAMA is not a requirement for certification testing.)

Financial aid was forthcoming from the American Medical Association to help us launch this program. For the past eight years Merck, Sharp and Dohme has contributed an annual grant of $5,000.00 toward the administration of this program.

There has been a steady increase both in the number of assistants taking the examination as well as the number of regional test centers throughout the country. There are now a total of 225 Certified Medical Assistants in the United States, eight of whom are in Michigan. The examination is difficut but it is not impossible for the candidate who prepares for it. It is broader than almost anyone's actual experience; therefore, few persons would be expected to pass without some review and study. A broad study outline of all sections of the examinations, with a list of reference books, is available upon request from the AAMA headquarters in Chicago.

Another step in the educational field for medical assistant is the recent formation of the Approval Program for medical assistants' courses in community junior colleges. Lederle Laboratories gave $5,000 to AAMA for implementation of this program. Until this time AAMA was one of the few para-medical groups that did not have an approval program, and because of this we were not able to recommend training programs to the hundreds of students who requested this information. The ground work has laid for a standardized training course for approved junior colleges throughout the United States — probably a two-year course leading to an associate arts degree in medical assisting. We are hopeful that this will help recruitment of trained medical assistants to fill the ever-increasing need in this field. This is an important long-range program and a major undertaking for AAMA. Northwestern Michigan College, in Traverse City, is one of the colleges participating with AAMA in this program.

Other educational opportunities provided by MSMAS for its members include the annual convention, which is held at the same time and in the same city as the MSMS convention, workshops, seminars and leadership training symposiums.

CONTINUED: MEDICAL ASSISTANTS

Other areas, not to be overlooked, are the *Bulletins* from both MSMAS and AAMA which carry invaluable articles for all medical assistants.

MSMAS IS AWARE of the need to meet the challenge of the "changing times" and will continue to strive to provide the best educational opportunities for all medical assistants and improve the quality (and quantity) of MSMAS in-service training programs.

Together with the high goals and standards we have set for ourselves through our organization we must also have some personal satisfaction by challenging ourselves to be knowledgeable, informed, enthusiastic and have as our first consideration the best interest of our employers and patients. □

To Improve Hospital . . .

Many suggestions are made every day to improve the hospitals in Michigan . . .

One of the recent ones at the University of Michigan Hospital was recorded by a 12-year-old boy, who suggested, "I would put the doctors in bed, and let the kids give the shots."

Parke-Davis Scientist Praises Work Performed By Zonal Centrifuge

A Parke, Davis & Company scientist has described the zonal centrifuge as a most useful instrument for large-scale purification of virus vaccines.

Dr. Manuel Rosenbaum, a research microbiologist in the Detroit laboratories of the pharmaceutical firm, said the zonal centrifuge, developed by Dr. N. G. Anderson, under the auspices of the Atomic Energy Commission and the National Institutes of Health, has been used "with great success in the continuous-flow processing of large volumes of crude vaccine materials with very efficient recovery of the immunizing agent and removal of essentially all extraneous matter."

Dr. Rosenbaum said that Parke-Davis had used the zonal centrifuge extensively in research operations, and he felt it would be a very useful adjunct in producing the improved purified-antigen influenza vaccine prepared by the ether-extraction method pioneered in the drug company's laboratories. □

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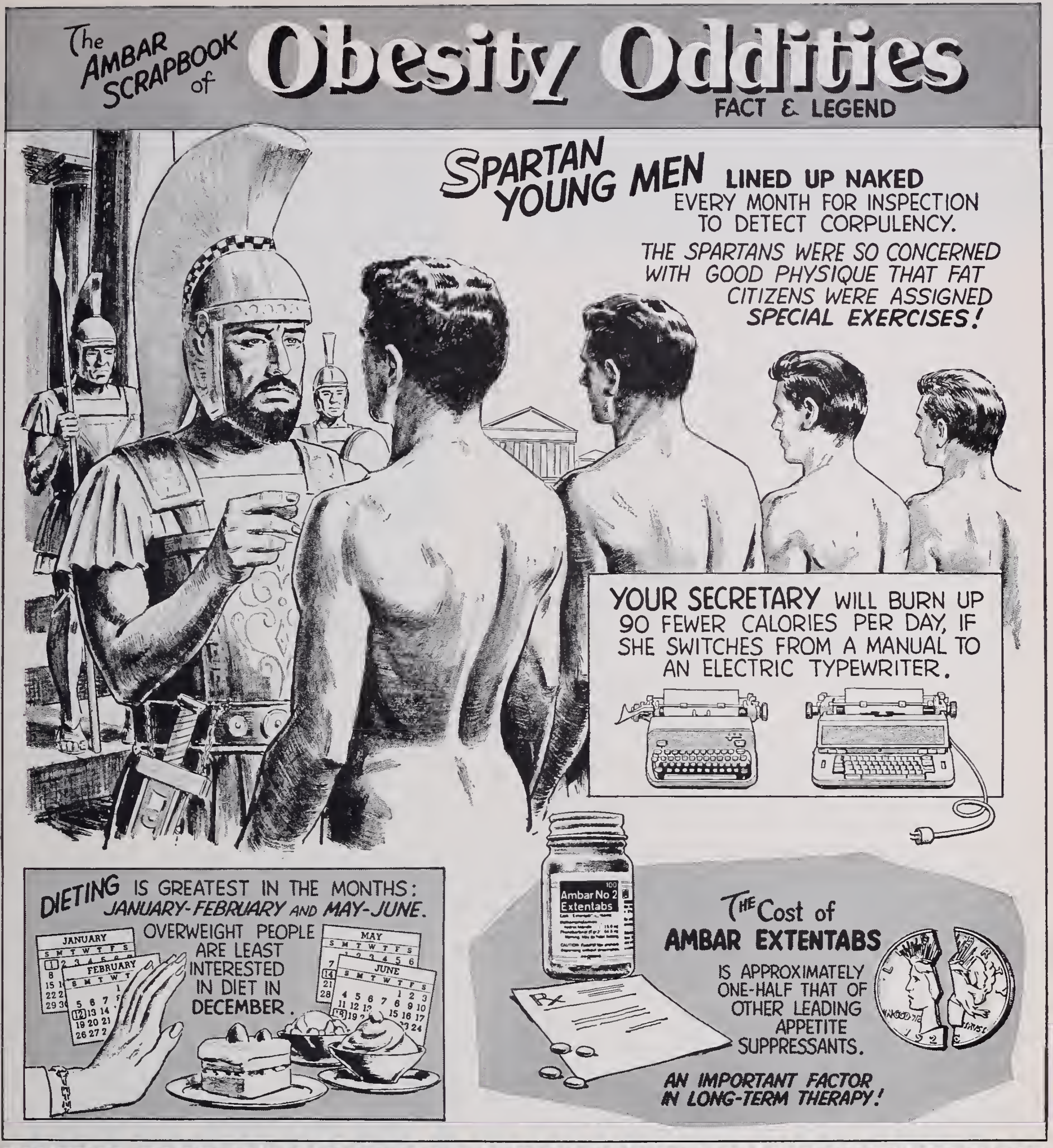
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IN MEMORIAM

V. D. Barnes, M.D., Livonia

Van D. Barnes, M.D., retired Livonia physician, died April 7, 1968, at the age of 76.

Doctor Barnes had carried on active practice for 46 years before his retirement. He was a 1915 graduate of the University of Michigan Medical School. Affiliated with U.S. Veteran's Administration hospitals for 30 years, he was a member of staff at the Dearborn V.A. Hospital from 1939 to 1961 and at the V.A. Hospital, Ann Arbor, from 1956-58. During World War I he served as a major in the Medical Corps.

He was a member of the American Legion, Rotary Club and Pi Upsilon Rho medical fraternity.

J. R. McBride, M.D., Lapeer

John R. McBride, M.D., Lapeer physician, died March 28 at the age of 64.

Doctor McBride had maintained a general practice in the Lapeer area for 30 years, having begun practice at North Branch. He received the M.D. degree in 1929 from the University of Iowa College of Medicine. During World War II he served as a captain in the Medical Corps.

LEGISLATURE PAYS TRIBUTE TO NORTHVILLE PHYSICIAN

The Michigan House of Representatives recently adopted a resolution memorializing the work of the late Irene L. Sparling, M.D., of Northville.

Doctor Sparling, who died in December 1967, worked for 40 years in Northville as a general practitioner, specializing in obstetrics-gynecology. She and her husband, Harold I. Sparling, M.D., both opened their practice there in July of 1925.

The conclusion of the resolution reads: "Resolved by the House of Representatives, that . . . a memorial of tribute be accorded Dr. Irene I. Sparling whose early determination to excell in medicine for the sake of future patients carried her to that goal, despite economic handicap; and who kept that trust faithfully, beyond the call of duty, for 40 years without fail." □

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Should Hospitals Adopt Seven-Day Week?

(Editor's Note: The following is excerpted from an editorial in the Bulletin of the Muskegon County Medical Society. Editor Robert M. Jesson wrote, in part, the following about the possibilities of hospitals operating seven days a week.)

"In view of recent activities in Muskegon, possibly additional service could be rendered to the patient by implementation of a 7 day week in our hospitals. This might interfere with the 3 and 4 day week of some of our colleagues, as well as the tendency of others to hospitalize people for several days ahead so as to obtain a good operating room time, but the lack of a two day gap out of every 7 certainly benefits most patients and doctors. Changes in laboratory service would be necessary too.

"It would seem to be an experiment well worth trying, especially if our local hospital costs are anywhere near that of the national average. Certainly a 6 to 12 month experiment in this could be accomplished with minimum difficulty and would provide some interesting figures for hospital administration.

"This idea should bear consideration in light of the present circumstances.

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Thomas V. Kretschmer, M.D., Saginaw,

was named recipient of the first distinguished alumnus award presented by St. Mary's High School in Saginaw. He was chosen because "he has been a humanitarian, has set an example of good Christian living and has contributed much to Saginaw," said the pastor of St. Mary's.

A. E. Humphrey, M.D., Marshall,

was honored at a testimonial dinner at Schuler's in Marshall and received a plaque presented by a member of the Social Services Board citing his "dedicated professional and personal service" to the aged and needy of the community.

Richard W. Dow, M.D., Ann Arbor,

an instructor in the U-M Medical School, is one of 25 medical researchers in the nation recently named as Markle Scholars in Academic Medicine. The Markle Foundation pays $30,000 at a rate of $6,000 yearly to the medical school at which a scholar is appointed.

Joseph F. Sadusk, Jr., M.D., Grosse Pointe,

has been elected to the Board of Directors of Parke, Davis and Company. Dr. Sadusk, who has served as associate dean of the Johns Hopkins University School of Medicine and as medical director of the Food and Drug Administration, is presently vice president, medical and scientific affairs at Parke-Davis.

Sidney E. Chapin, M.D., Dearborn,

medical director of the Visiting Nurse Association Home Care Program of Detroit, participated on the program of the 38th Annual Tri-State Hospital Assembly in Chicago. He served on a panel and also presented a paper entitled "Building Physician Support for Home Care."

MSMS MEMBERS IN THE NEWS

BY CAROL MAXWELL
OF THE MSMS STAFF

Michigan
State
Medical
Society

Bonnie R. Wolfram, M.D., Grosse Pointe,

has accepted the chairmanship of a new national committee named by George Lingua, president of the National Kidney Foundation. The committee's purpose is to implement programs for prolonging life and restoring to useful activity victims of kidney failure.

Dr. Wolfram's group, the Trustees' Dialysis and Transplantation Committee, will consider sources for financing of patient care for the 6,000 to 10,000 individuals annually needing artificial kidney treatment (hemodialysis) or transplantation in order to survive.

Jack Lapides, M.D., Ann Arbor,

professor of surgery in the University of Michigan medical school, was presented the William P. Burpeau Award and honored as "one of the nation's outstanding urologists," by the American Academy of Medicine, Urology Section, at a recent meeting of the Academy in West Orange, N. J. He delivered a lecture on "New Concepts Regarding Urinary Infections."

Donald L. Schaefer, M.D., John S. Wyman, M.D., and Robert E. Anderson, M.D., all of Ann Arbor,

were participants on the program of the 46th Annual Meeting of the American College Health Association in Minneapolis.

Paul E. Derleth, M.D., Ferndale, and Norman J. Goode, M.D., Detroit,

were promoted to new positions in the Detroit Edison Company. Doctor Derleth is the new medical director and Doctor Goode will serve as assistant medical director.

Otto Von Renner, M.D., Reese,

longtime Vassar general practitioner, celebrated his 95th birthday recently. "I live very simply, enjoying the common things," he said.

Harold T. Donahue, M.D., Cass City,

was named Cass City Citizen of the Year at a recent Chamber of Commerce dinner.

Muir Clapper, M.D., Detroit,

Professor of Medicine at Wayne State University School of Medicine, has been elected to a three-year term on the Board of Governors of the American College of Physicians. Elections were held at the College's 49th Annual Session in Boston recently.

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MICHIGAN MEDICINE

Read This Issue for Topics, Speakers For 1968 Annual Session Program

Doctors of medicine, wives, medical assistants, nurses, senior medical students, interns and residents, are invited to participate in the Annual Scientific Session of the Michigan State Medical Society to be held at the Sheraton-Cadillac Hotel in Detroit on Wednesday and Thursday, September 25-26.

The scientific program, composed of courses, general sessions, and section meetings, will be preceded by the annual House of Delegates meeting. The delegates will be in session Sunday night, September 22, and all day, September 23 and 24.

SCIENTIFIC MEETINGS ON Wednesday, September 25, will focus on breast carcinoma, trauma, pediatric problems, the relief of pain, and other subjects. Infectious diseases and pulmonary diseases will be studied in the courses during that day.

General meetings on Thursday, September 26, will deal with cardio-vascular diseases, prostate carcinoma and calcium, psychoanalytic problems of the aging population, transplantation, cancer, thyroid, infectious diseases, shock, gastro-intestinal tract diseases, and other subjects.

Courses on gastro-intestinal tract diseases and blood diseases will be held throughout the day, September 26.

CHAIRMAN OF THE Annual Session Program Committee is Alexander J. Walt, M.D., chairman of the surgery department at Wayne State University Medical School.

The Woman's Auxiliary to MSMS will hold its annual convention September 24-25-26 at the Statler-Hilton in Detroit.

The Michigan State Medical Assistants Society will be in session September 25-26 for its annual convention at the Pontchartrain Hotel.

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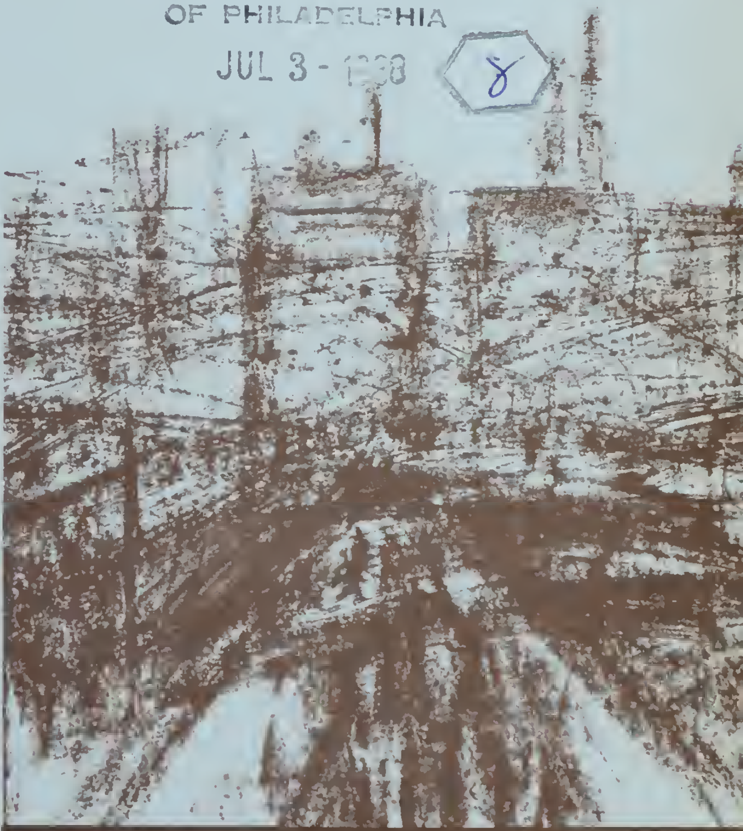

Urge Every MSMS Member Attend September 25-26

1968 Annual Session Program

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Wednesday Morning, September 25

Breakfast Roundtable Discussion on Obstetrics-Gynecology
Sponsored by Section on Obstetrics and Gynecology

Two All-Day Postgraduate Courses (advance registration only):

Infectious Diseases
A. Martin Lerner, MD, Moderator, Wayne State University

Pulmonary Diseases
Benjamin M. Lewis, MD, Moderator, Wayne State University

Breast Carcinoma: General Session
Moderator: Alexander J. Walt, MD, Wayne State University

The Problems and Aspects of Cure—Mammography and Xerography
John A. Wolfe, MD, Detroit

Indications and Results of Chemotherapy in the Management of Breast Cancer
Vainutis K. Vaitkevicius, MD, Wayne State University

Aspects of Palliation—Surgical Aspects
William J. Fry, MD, University of Michigan

Title to be selected
Doctor M. Betty Bennett, University of Capetown, Capetown, South Africa

Aspects of Palliation
Cushman D. Haagensen, MD, Columbia University

Title to be selected
William L. Donegan, MD, University of Missouri

Selective Abdominal Arteriography: General Session
Moderator: Roger L. Rian, MD, Detroit
Angiography in Liver Diseases, Splenic Pathology, Pancreatic, Gastric, Small and Large Bowel and Renal Diseases
Manuel Viamonte, Jr., MD, University of Miami

Problems of the Fetus: General Session

Section Programs and Business Meetings:

Dermatology
Panel on Oral Mucous Membrance Lesions

Obstetrics and Gynecology
(See Breakfast Roundtable Discussion)

General Luncheon

Two Postgraduate Courses (Continued from morning session)

Trauma: General Session

Sponsored by Section on Surgery
Moderator: Paul W. Gikas, MD, Ann Arbor

Title to be selected
J. Cuthbert Owens, MD, University of Colorado

The Extrication of Injured Personnel from Wrecked Vehicles
Colonel Louis C. Kossuth, MC, USAF, ENT Air Force Base, Colorado

Trauma (Second Meeting)
Moderator: Robert F. Wilson, MD, Wayne State University

Pediatric Problems: General Session

Relief of Pain: General Session

Sponsored by Section on Anesthesiology and Michigan Society of Anesthesiologists

Moderator: Shirley Austin, MD, Detroit
John W. Ditzler, MD, Chicago

Fireside Discussions

Speaker Discussants:

Paul W. Gikas, MD, Ann Arbor
Jerome A. Gold, MD, Woman's Medical College of Pennsylvania
Kaye H. Kilburn, MD, Duke University
Louis C. Kossuth, Colonel, USAF, MC
Gordon L. Snider, MD, Boston University

Section Programs and Business Meetings

Anesthesiology
(See General Session above)
Allergy and Applied Immunology
General Practice
Ophthalmology
Otolaryngology
Pediatrics
Physical Medicine
Plastic Surgery
Public Health and Preventive Medicine
Radiology
Surgery
(See General Session above)

1968 Annual Session Program - Continued

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Thursday Morning, September 26

Breakfast Roundtable Discussion on Urology
Sponsored by Section of Urology and Detroit Urological Society

Breakfast Roundtable Discussion on Proctology
Sponsored by Section on Proctology

Breakfast Roundtable Discussion on Anesthesiology
Sponsored by Section on Anesthesiology and Michigan Society of Anesthesiologists, Inc.

Two All-Day Postgraduate Courses (by advance registration only):
Blood Diseases
Arnold R. Axelrod, MD, Moderator, Detroit
Difficult Decisions in Digestive Diseases

Cardiovascular Diseases: General Session
Sponsored by Section on Internal Medicine
Moderator: Richard J. Bing, MD, Wayne State University
Jack H. Kaufman, MD, Detroit

Prostate Carcinoma: General Session
Moderator: Edward J. Shumaker, MD, Wayne State University
George T. Mellinger, MD, University of Minnesota
Willet F. Whitmore, Jr., MD, Cornell Medical College

Calcium—Too Much, Too Little: General Session
Moderator: Richard W. Smith, MD, Detroit
Louis V. Avioli, MD, Washington University School of Medicine
Robert D. Johnson, MD, University of Michigan
Boy Frame, MD, Detroit

Section Programs and Business Meetings:
Anesthesiology
(See Breakfast Roundtable Discussion above)
Internal Medicine
(See General Session above)
Pathology (All Day Meeting)
Slide Seminar on Diseases of Skeletal Muscle
Proctology
(See Breakfast Roundtable Discussion above)
Occupational Medicine
Capacitance Respirometry—A New Method of Measuring Lung Impairment
Urology
(See Breakfast Roundtable Discussion above)

General Luncheon:

Organ Transplantation
David Hume, MD, Medical College of Virginia

Thursday Afternoon, September 26

Two Postgraduate Courses (continued from morning session)

General Session:

What's New in the Practice of:

Cardiovascular Diseases
Cancer
  Michael J. Brennan, MD, Wayne State University
Transplantation
  David Hume, MD, Medical College of Virginia
Urology
  George T. Mellinger, MD, University of Minnesota
  Willet F. Whitmore, Jr., MD, Cornell Medical College
Gynecology
  Samuel J. Behrman, MD, University of Michigan
G-I Tract Diseases
  J. Edward Berk, MD, California College of Medicine
Infections and Antibiotics
  A. Martin Lerner, MD, Wayne State University
Pediatrics
  Charles F. Whitten, MD, Wayne State University
Endocrine Diseases
  Raymond C. Mellinger, MD, Detroit

Diabetes: General Session

Co-Sponsored by Michigan Diabetes Association
Moderator: Fred W. Whitehouse, MD, Detroit
Pathophysiology of Acute Metobolic States in Diabetes
  Buris Boshell, MD, Medical College of Alabama
The Management of the Diabetic Coma and the Diabetic in Coma
  George F. Cahill, Jr., MD, Harvard University

Psychiatric Problems of the Aging Population: General Session

Moderator and Discussant: Lawrence Koltonow, MD, Southfield
  Henry W. Brosin, MD, University of Pittsburgh

Section Programs and Business Meetings:

Neurological Surgery
Pathology
  (continued from morning session)
Psychiatry and Neurology
  Panel on American Medicine and the Development of an American Style of Psychiatry
Orthopaedic Surgery
Thoracic Surgery

Master Timetable for MSMS Activities In Detroit for Week of September 22

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Sunday, September 22

Meeting of MSMS Council

Delegates Workshop

Speakers' Dinner (For Reference Committee Chairmen)

MSMS House of Delegates Convenes

* * *

Monday, September 23

MSMS House of Delegates

Reference Committee Meetings

* * *

Tuesday, September 24

MSMS House of Delegates

Reference Committee Meetings

Michigan Medical Service Members Meeting

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Awards Luncheon

Past Officers Dinner and Meeting

* * *

Wednesday, September 25

MSMS Exhibition of Technical Displays

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Michigan State Medical Assistants Society Annual Meeting (Pontchartrain Hotel)

- House of Delegates
- Presidents Luncheon
- Annual Banquet

MSMS Scientific Program

- Breakfast Roundtable Discussions
- Postgraduate Courses (All-Day Seminars)
  - Infectious Diseases
  - Pulmonary Diseases
- Panel Discussions and Assembly Presentations
  - Breast Carcinoma
  - Abdominal Arteriography
  - Problems of the Fetus
  - Trauma
  - Pediatric Problems
  - Relief of Pain
- General Luncheon (With Special Speaker)
- Fireside Discussions with Speakers

Section Meetings and Special Programs

- Allergy and Applied Immunology
- Anesthesiology
- Dermatology
- General Practice
- Obstetrics and Gynecology
- Ophthalmology
- Otolaryngology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Public Health and Preventive Medicine
- Radiology
- Surgery

Specialty Society Cooperating Groups

- Detroit Roentgen Ray Society
- Michigan Society of Anesthesiologists

* * *

Thursday, September 26

Reorganizational Meeting of The Council

MSMS Exhibition of Technical Displays

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Michigan State Medical Assistants Society Annual Meeting (Pontchartrain Hotel)

- Educational Program
- Installation Luncheon

Thursday, September 26, Continued

MSMS Scientific Program

- Breakfast Roundtable Discussions
- Postgraduate Courses (All Day Seminars)
  - Blood Diseases
  - Digestive Diseases
- Panel Discussions and Assembly Presentations
  - Cardiovascular Diseases
  - Prostate Carcinoma
  - Calcium — Too Much, Too Little
  - What's New in Practice of . . .
    - Cardiovascular Disease
    - Cancer
    - Transplantation
    - Urology
    - Gynecology
    - G-I Tract Diseases
    - Infection and Antibiotics
    - Pediatrics
    - Endocrine Diseases
  - Diabetes
  - Psychiatric Problems of Aging Population
- General Luncheon
  - Special presentation on "Organ Transplantation"

Section Meetings and Special Programs

- Anesthesiology
- Internal Medicine
- Occupational Medicine
- Orthopedic Surgery
- Neurological Surgery
- Pathology
- Proctology
- Psychiatry and Neurology
- Thoracic Surgery
- Urology

Specialty Society Cooperating Groups

- Detroit Urological Society
- Michigan Diabetes Association
- Michigan Orthopaedia Society
- Michigan Society of Anesthesiologists
- Michigan Society of Neurological Surgeons
- Michigan Society of Pathologists
- Michigan Society of Psychiatry and Neurology

> *"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."*
>
> —*AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

MSMS to Appoint New Committee On Quackery; Plan Approved

The appointment of a new "MSMS Committee on Quackery" was approved by the MSMS Council at its June 5 meeting, acting upon recommendations from the April 1 invitational conference held by MSMS at its headquarters to explore possible areas of MSMS activities.

The report of the April 1 working conference suggested that MSMS could implement an "action program" through a committee. The committee, according to recommendations approved by The MSMS Council, will take the following three steps:

"1. To meet with appropriate officials in the Department of the Attorney General to prepare legislation better defining "quackery" and setting stiffer penalties; to develop consumer fraud educational programs for presentation to civic clubs; and to assist the Department in obtaining sufficient budget and personnel to investigate and prosecute health frauds. (The MSMS PR Committee previously recommended a Committee on Quackery and The Council concurred, but no Committee has been named)

"2. To confer with Michigan state school officials (Department of Public Instruction, appropriate universities, and school administrators) to develop programs of education for physicians, teachers and pupils regarding health quackery, particularly nutritional misinformation.

"3. To consider the ways and means by which the medium of television can be most effectively used as a mass education technique regarding health quackery, thus particularly taking the necessary message to all segments of the society and particularly the shut-in elderly."

The April 1 conference was attended by legislators, law enforcement officials, federal agency representatives, health agency officers, the press, and physicians.

Offer New Blue Cross-Shield Coverage for MSMS Members

The Michigan State Medical Society will offer eligible members a new, expanded Blue Cross and Blue Shield program, known as MVF-2, effective August 1, 1968.

Those members presently enrolled will be automatically changed to this new coverage on that date.

Those members not now enrolled may obtain this new program at the same time if you act within the time schedule.

The new program will introduce benefits for care in convalescent facilities — outpatient psychiatric care — expanded benefits for nervous and mental conditions — plus the new Michigan Variable Fee system for paying physicians their reasonable and customary charges. All of this will be in addition to the basic Blue Cross hospital care benefits and Blue Shield physician care benefits.

Further information will be mailed in the latter part of June from Robert J. Mason, M.D., Chairman of the Council, to every MSMS member. His covering letter explains that "this expanded Blue Cross and Blue Shield program is based on the recommendation of the MSMS Committee on Professional Insurance Plans."

MSU Allocated $1 Million for Med Building

Michigan State University is moving ahead with plans for its first medical school building.

The State Legislature recently appropriated $1 million for initiating construction of the Life Sciences Building during the 1968-69 fiscal year with the understanding that an additional $3 million will be needed in the following two years.

Additional money needed for the building is expected from federal and private sources.

The Kellogg Foundation has already granted $625,000 in support of the construction, and three agencies of the United States Public Health Service have approved, but not funded, grant requests totaling $5 million in support of the construction.

The Life Sciences Building will enable MSU to expand each entering medical student class from 26 to 64 students, to double the number of nurses it is graduating, and to greatly increase its graduate and postdoctoral enrollments in pharmacology.

The buildings will house the Department of Medicine, the Department of Pharmacology, the School of Nursing and administrative offices of the College of Human Medicine and the College of Veterinary Medicine.

Dedicate Cancer Research Center

The vision and hard work of the late G. Donald Cummings, M.D., have materialized in the recent dedication of the $900,000 G. Donald Cummings Cancer Products Development Center in Lansing.

The State Public Health Department research center will work on the acceleration of new chemical compounds to treat cancer. Since 1956 the Public Health Department has been engaged in cancer research to discover and develop drugs to effectively treat the disease.

Doctor Cummings, who led efforts to get the legislature to appropriate money for the Center, died last year. He had been director of health department laboratories since 1944.

Doherty Receives Governor's Award

John A. Doherty, executive director of the Michigan Health Council, was one of 50 leaders who received Michigan Minuteman awards recently.

Governor Romney gave the awards in recognition of "extraordinary and distinguished service as spokesmen for Michigan and for promoting the state" at a ceremony in front of the Capitol.

APPRECIATIVE!

Thank you so very much for the excellent article by Phyllis Marquardt that you published for the Medical Assistants in the June issue of *Michigan Medicine*. It's always so good to see MSMAS in print . . . and a beautiful spread . . . thanks!

Betty Lou Willey, CMA
Port Huron
AAMA Speaker
MSMAS Past President

HONOR TO HANLON

John J. Hanlon, M.D., class of 1940, was one of the six "distinguished alumni" of Wayne State University to be honored at the Centennial Reunion.

Contributions by Doctors Given 3 Medical Schools

Checks for $20,431.63 were presented to the three Michigan medical colleges by MSMS officers in a ceremony June 5 at the headquarters.

The checks represented recent contributions by Michigan physicians and others for medical schools at the University of Michigan, Wayne State University and Michigan State University. The checks were from the American Medical Association Education and Research Foundation, which handles direct contributions to each of the 94 medical schools and also prorates general contributions by physicians and other interested individuals, companies and foundations.

The University of Michigan check was for $12,203.11; Wayne State University for $6,911.91, and Michigan State University for $1,317.61. The contributions are unrestricted and can be used by the medical schools for whatever purpose the school has greatest need, explains Robert J. Mason, M.D., Chairman of The MSMS Council.

A check to the University of Michigan Medical School from the AMA-ERF is presented to Fred J. Hodges, M.D., right, representative of the medical school, by B. M. Harris, M.D., Ypsilanti, MSMS President.

A check to the Wayne State University Medical School from the AMA-ERF is presented by Robert J. Mason, M.D., right, MSMS Council Chairman, to Muir I. Clapper, M.D., representative of the WSU school.

A check to the Michigan State University College of Human Medicine from the AMA-ERF is presented to Dean Andrew Hunt, Jr., M.D., left, by Kenneth H. Johnson, M.D., Lansing, MSMS Secretary.

ADD: IN MEMORIAM

In addition to the names reported in the June "In Memoriam," the following news has reached the MSMS office. Details will follow in the July *Michigan Medicine*:

Randall M. Cooley, M.D., Jackson, died May 20.

Harry F. Dibble, M.D., Detroit, died May 10.

Nathan H. Goldberg, M.D., Detroit, died May 4.

Joseph Hickey, M.D., Dearborn, died April 12.

George W. Stewart, Jr., M.D., Saginaw, died May 13.

EDITORIAL REPRINTED

A *Michigan Medicine* editorial by George H. Lowrey, M.D., about Foreign Physicians was reprinted in the May 13 issue of the *AMA News.*

Brooker L. Masters, M.D., Fremont, and Sharon McAfee, of the MSMS staff, examine a display and a new brochure which the Michigan Health Council, in cooperation with Consumers Power Company of Jackson, is distributing in hope of attracting family physicians to practice medicine in rural areas of Michigan. Copies of the folder are available from the Michigan Health Council, 712 Abbott, East Lansing 48823. (An article about the brochure appeared in the June issue of MICHIGAN MEDICINE.)

MHC PLACES 69 DOCTORS IN STATE, 10 MONTHS

The Michigan Health Council M.D. Placement Service has assisted 69 physicians in locating in Michigan communities during the past 10 months compared to 59 during the same period of 1967. Since January 1, 1968, 21 doctors and communities have been helped including Gaylord, Allegan, Grand Haven, Baldwin, Mt. Pleasant, Ishpeming, Petoskey, Kalamazoo, Grand Rapids, and Battle Creek. There still are more than 124 communities seeking family physicians and 55 seeking medical specialists.

Michigan Health Council recently conducted a survey to determine how many physicians, dentists, osteopaths, registered nurses, practical nurses and dental hygienists there are in each county. The survey showed Michigan had one MD for every 1,014; one DO for every 4,375; one DDS for every 1,986; one RN for every 205; one LPN for every 494; and one RDH for every 7,143.

The following totals are reported by Michigan Health Council for Michigan, which showed a population of 8,500,000:

8,379 – M.D.
1,943 – D.O.
4,279 – D.D.S.
41,410 – R.N.
17,213 – L.P.N.
1,190 – R.D.H.

Complete statistical reports for the many counties, are available from Michigan Health Council, 712 Abbott Road, East Lansing, Michigan 48823.

Named by Governor To Help Handicapped

Jens D. Henriksen, M.D., Battle Creek, is one of 20 Michigan professional and businessmen who will serve on the Governor's Commission on Employment of the Handicapped. Doctor Henriksen directs the Department of Physical Medicine and Rehabilitation of the Battle Creek Rehabilitation Institute.

Public Act 11 of 1968 made the commission official and placed it in the Department of Education. The commission works closely with the State Department of Education's Vocational Rehabilitation Division and the Michigan Employment Security Commission.

MCHSS Names Action Committees; 61 Recommendations under Study

Meetings during June and July are scheduled for the six Michigan Community Health Services Study regional task forces "to determine priorities for implementation . . . and to develop appropriate action plans."

The MCHSS (a cooperative project of the University of Michigan School of Public Health, the Michigan Department of Public Health and the Michigan Health Officers Association) has recently appointed 10 action committees. The only physician appointed as an action committee chairman was Richard D. Mudd, M.D., Saginaw, named chairman of the Water Pollution and Other Environmental Health Services Committee.

The 315 members and consultants of the Regional Task Forces and the parent Committee of Forty, recently rated the 61 recommendations of the proposed final report on a priority basis.

No. 1 top priority was given to a proposal calling for "the establishment of state and area-wide comprehensive health planning programs and advisory councils, with the majority of the members being consumers of health services."

MAGP TO CONDUCT SMOKING WORKSHOP AT MSU, OCT. 20

The Michigan Academy of General Practice will conduct a physician workshop on Smoking and Related Disease at Michigan State University's Kellogg Center, October 20, 1968. Member organizations of the Michigan Council on Smoking and Health are being asked to help plan and conduct the workshop. MSMS planning efforts will be headed by Oscar D. Stryker, M.D., chairman of the MSMS Committee on Public Health.

Says Police Using Mace Should Have Special Training

Chemical Mace can be used with comparative safety as a weapon to incapacitate a person temporarily if certain precautions are taken, says Maurice H. Seevers, M.D., chairman of the University of Michigan department of pharmacology. He has declared that if the controversial spray is used properly there is no danger to a person's eyes or other organs or tissues.

Doctor Seevers suggested that officers responsible for using Mace should be carefully taught its proper use and the potential hazards of indiscriminate use or accidental misuse.

Doctor Seevers has completed testing the controversial spray on monkeys and rabbits in department laboratories at the U-M Medical School. The research was undertaken at the request of Ann Arbor City officials after local police suspended use of the weapon.

Doctor Seevers did report also that "severe, long-term, and possibly permanent ocular damage may occur if the cornea of the eye is exposed directly to Chemical Mace in liquid form. Such exposure resulting from discharge of the canister would, in our opinion, constitute misuse of the weapon."

Newspapers Describe New MSMS Efforts to Combat Quackery

In a further effort to combat quackery, MSMS sponsored a recent workshop that resulted in many news articles in the Michigan press.

The conference, at the MSMS headquarters for selected legislators, law-enforcement officials, educators, attorneys and lay leaders, was well covered by the press.

Articles appeared in the many newspapers with the following typical headlines:

Kalamazoo Gazette: "Medical Society Says 'take' Huge: Seeks Curb of Health Quackery."

Benton Harbor News Palladium: "Michigan Fighting Health Quacks."

Ypsilanti Press: "State Doctors Aim at Quacks."

Bay City Times: "Crack down on Quackery Planned; Medical Society Campaign."

Battle Creek Enquirer and News: "Doctors Declare War on Health Quacks."

And there were many, many others, all reflecting the MSMS concern.

BACK IN DETROIT FROM HOPE SHIP

Recently returned from a two month tour of duty with the Hope Ship is Henry VandenBerg, Jr., M.D., of Detroit. Doctor VandenBerg served in Colombo, Ceylon, the seventh trip made by the Hope Ship.

AMA CITES TWO MSMS PR EFFORTS

The current issue of *PR Doctor,* publication of the AMA as "a working guide to positive medical public relations," carries two articles about MSMS.

One story tells about the 1967 MSMS Annual Session feature of offering the registrants the chance to "have lunch with the speakers."

Another item describes some of the many MSMS activities with and for the students at the three Michigan medical schools. The article contends that "medical societies, in responding to students today, can look forward to more responsive members tomorrow."

Jaffar to Lead Urologists 1969-70

Recently chosen president-elect of the American Urological Association was Donald J. Jaffar, M.D., Detroit.

Doctor Jaffar, clinical professor of urology at the Wayne State University School of Medicine, was so honored at the annual convention at Miami.

He will be installed as president for 1969-70 next May.

MIDLAND M.D. NOW IN VIETNAM

Most recent member of the Volunteer Physicians for Vietnam, sponsored by the American Medical Association, is Henry C. Scharnweber, M.D., a general practitioner with the Dow Chemical Company in Midland, Michigan. Doctor Scharnweber joins the ranks with many other Michigan physicians who have served in the program.

Leon Swatzell, right, the new AMA field representative assigned to Michigan and several other midwest states, attended the recent June meeting of the MSMS Council. Council projects and MSMS committee work are explained to Mr. Swatzell by Robert J. Mason, M.D., left, Chairman of The Council. Mr. Swatzell will visit the MSMS House of Delegates and the Annual Session in September and will serve as the liaison representative between the AMA and the MSMS and Michigan county medical societies.

Opinion Says Different Fees OK For Ophthalmologists Optometrists

The following opinion of the Michigan Attorney General about fees for ophthalmologists and optometrists is quoted from the *AMA Citation* publication:

"Statutes allowing a person covered by health insurance to have a free choice of either an ophthalmologist or an optometrist for optometric services and requiring public agencies to accept the services of an optometrist on the same basis as those of any other person licensed to render a similar service do not prohibit different fee schedules for ophthalmologists and optometrists for performing the same or similar services. The Attorney General of Michigan so ruled in a recent opinion.

"An optometrist merely examines eyes for refractive error, while an ophthalmologist is a duly licensed physician who specializes in the care of eyes. Because of the differences between ophthalmologists and optometrists as to knowledge, skill, training, approach, methods employed, and professional responsibility, different fee schedules for similar services are permissible. Statutory provisions requiring that the two professions be treated on a parity relate to the employment of the services of members of the professions, not to the payment of fees.—*Opinion of the Michigan Attorney General*, No. 4497 (Mich., March 19, 1968)"

HOUGHTON GIRL WINS SCIENCE AWARD

One of the six Award of Merit citations presented by the American Medical Association at the 19th International Science Fair in Detroit recently was won by Miss Cathleen Work, 16, a senior at Houghton Central High School in Houghton.

Miss Work explains that she undertook her exhibit-study, "The Effects of Inhibiting the Thyroid," to discover the effects of propylthiouracil on rabbits. Through observation and measurements she recorded changes in heart rate, weight, metabolism, and bone growth.

Another Award of Citation was presented to Thomas J. Moore, 17, of Homewood, Illinois, who is a junior at St. Augustine Seminary, Holland. His work was about "The Extent of Subliminal Perception."

Presenting the awards was Milford O. Rouse, M.D., of Dallas, president of the AMA. James L. Lightbody, M.D., of Detroit, MSMS president-elect, represented Michigan physicians at the speakers table.

"Unwed Mother" Topic July 25-26 For Coller Event

One of the highlights at the 48th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 25-26, will be a one-hour panel discussion on "The Unwed Mother."

The panel from 4 to 5 p.m., July 25, will spotlight three University of Michigan physicians—J. Robert Willson, M.D., professor and chairman of the Department of Obstetrics and Gynecology; William J. Oliver, M.D., professor and chairman of the Department of Pediatrics and Communicable Diseases, and Stuart M. Finch, M.D., professor of psychiatry and chief of Children's Psychiatric Service.

The annual conference will offer many nationally-known speakers from Michigan and across the nation.

James W. Hall, M.D., Traverse City, who is serving as chairman of the local committee on arrangements, will begin the conference with the official welcome at 9 a.m., July 25. Adjournment is scheduled for noon, July 26.

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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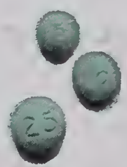

(in Libritabs™)

(chlordiazepoxide)

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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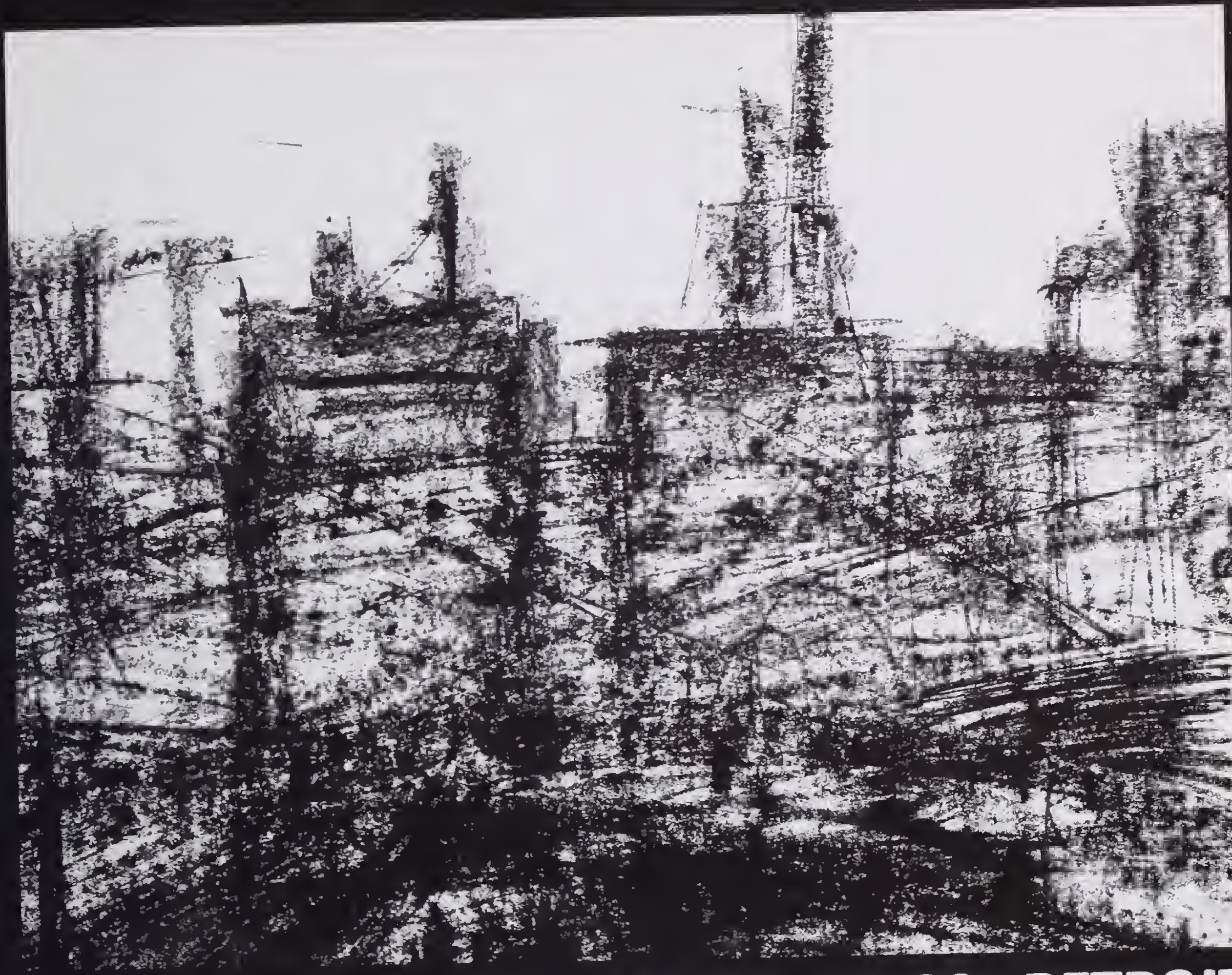

SEPTEMBER 25-26, DETROIT
1968 MSMS ANNUAL SESSION

SEPT. 25-26
is the time to participate in the 103rd MSMS Annual Session. Listen to medical authorities, participate in conferences, see the exhibits, enroll in a one-day course, visit with your confreers, attend a specialty session, have fun at the Annual MSMS Dinner Dance, etc., etc.

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PG REFRESHER COURSE - NO REGISTRATION FEE

Open-eyed nights

Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

ROCHE
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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium®(diazepam)

useful for the relief of psychic tension, alone or with associated depressive symptoms

MICHIGAN MEDICINE

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Many Articles

In every issue of MICHIGAN MEDICINE there are articles of value and interest to every MSMS member. Some members want scientific papers, others primarily want information about MSMS and its projects, others want to read about the activities of the many ancillary organizations, and still others have other special interests. This July issue and every issue offers a blend of all these articles. Comments are always invited from MSMS members as are original scientific articles.

RECOMMENDED

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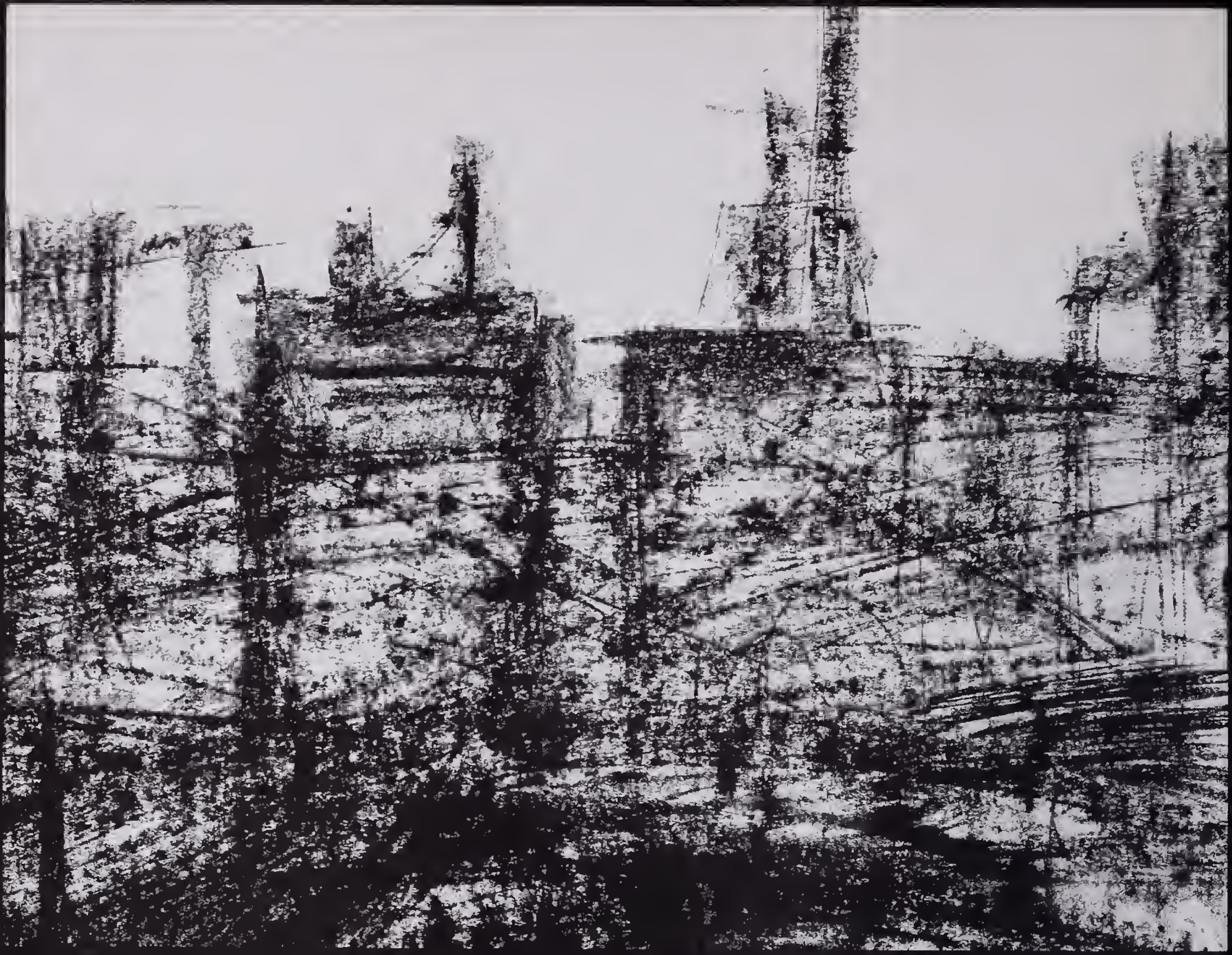
ICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 13 · JULY 1968

MARK YOUR CALENDAR — ALL IN DETROIT

Sept. 22-24 — MSMS House of Delegates
Sept. 25-26 — MSMS Annual Scientific Session
Sept. 24-26 — Woman's Auxiliary to MSMS
Sept. 25-26 — Michigan State Medical Assistants Society
Sept. 22 - Oct. 20 — "Ars Medica Art Exhibit"



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HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

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IN A COMPLETE,

STERILE,

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PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

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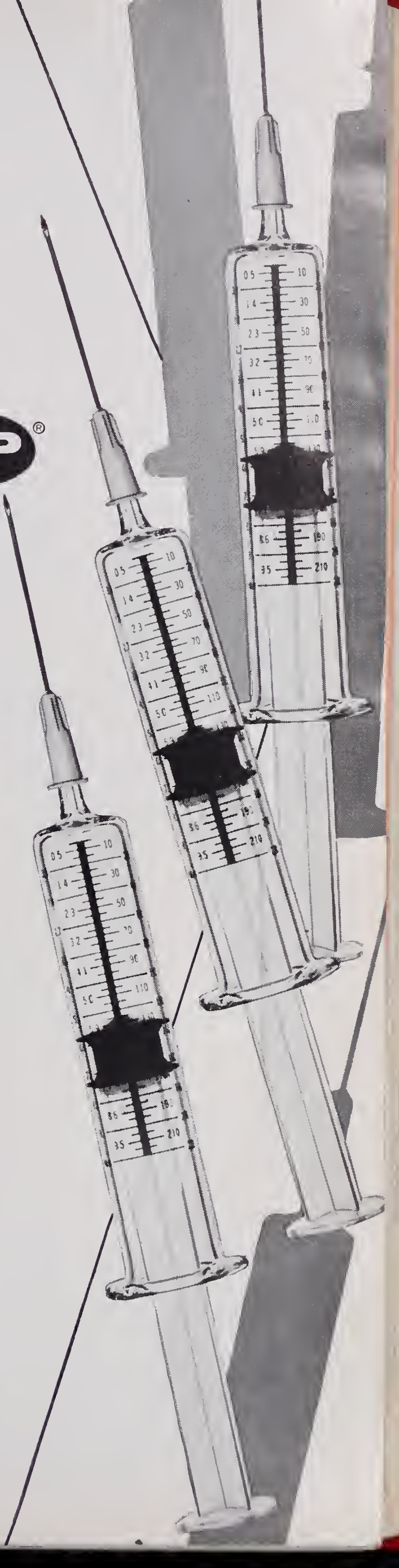

MICHIGAN MEDICINE

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The art work on the MSMS Annual Session ad on the inside front cover is a charcoal sketch "Cityscape" by Mrs. Clara Rogers of Birmingham. It will be used throughout the summer in all the MSMS promotional efforts for the Annual Session to be held in Detroit, September 25-26. Mrs. Rogers works in many media and has had many works on exhibit in Detroit and other cities.

OFFICIAL PUBLICATION • MICHIGAN STATE MEDICAL SOCIETY

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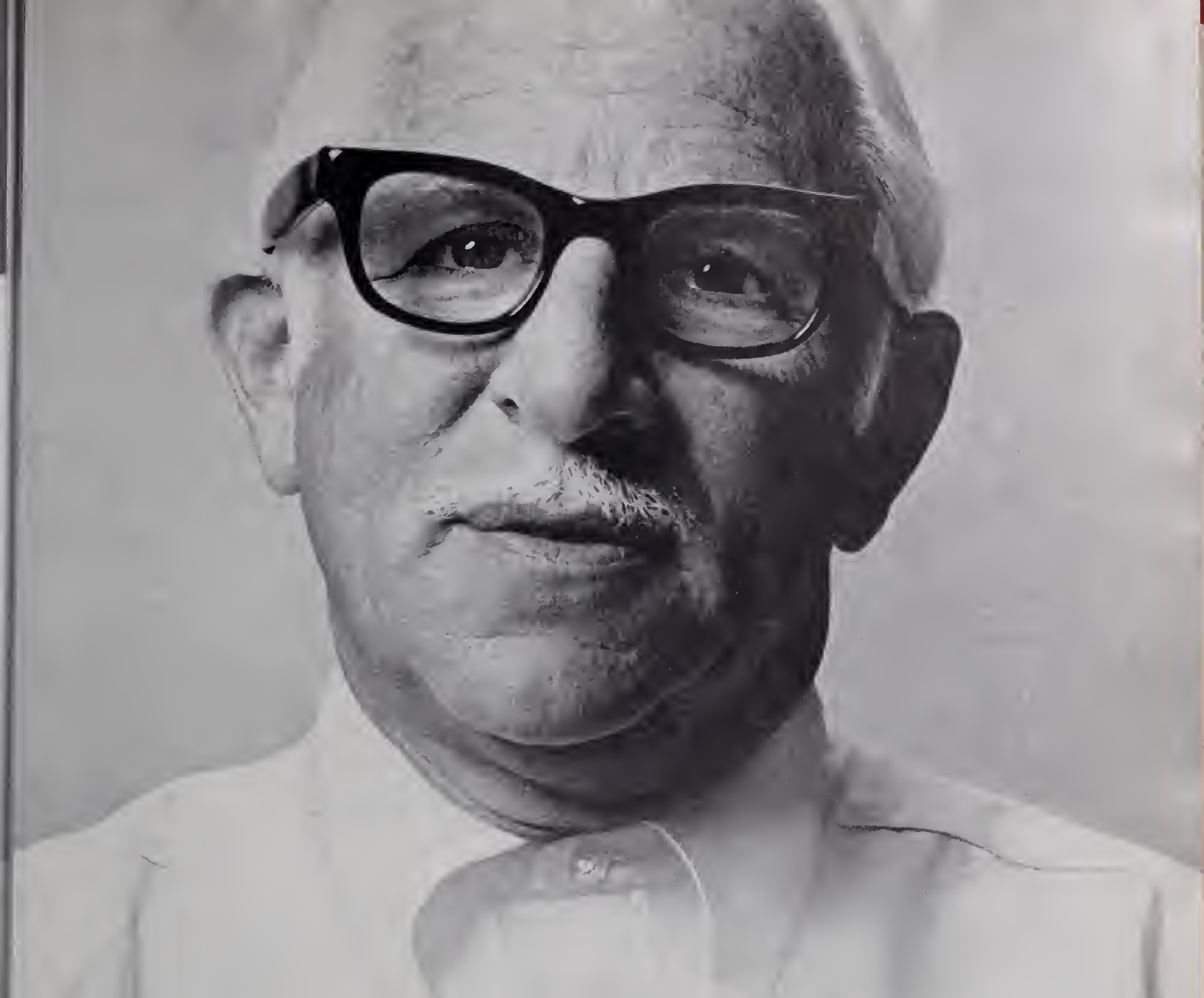


He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

guard susceptible patients against intestinal monilial over-wth during broad-spectrum therapy—the protection of statin is combined with demethylchlortetracycline in CLOSTATIN.

'or your susceptible candidates, prescribe DECLOSTATIN ne broad-spectrum therapy that prevents monilial rgrowth.

traindication: History of hypersensitivity to demethylchlortetracy-e or nystatin.

-ning: In renal impairment, usual doses may lead to excessive accumu-on and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations be advisable. A photodynamic reaction to natural or artificial sun-it has been observed. Small amounts of drug and short exposure may duce an exaggerated sunburn reaction which may range from ery-ma to severe skin manifestations. In a smaller proportion, photo-rgic reactions have been reported. Patients should avoid direct osure to sunlight and discontinue drug at the first evidence of skin comfort. Necessary subsequent courses of treatment with tetracy-nes should be carefully observed.

cautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transien increase in urinary output, sometimes accompanied by thirst (rare) Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis Teeth—dental staining (yellow-brown) in children of mothers given thi drug during the latter half of pregnancy, and in children given the dru during the neonatal period, infancy and early childhood. Enamel hypo plasia has been seen in a few children. If adverse reaction or idiosyn crasy occurs, discontinue medication and institute appropriate therapy.

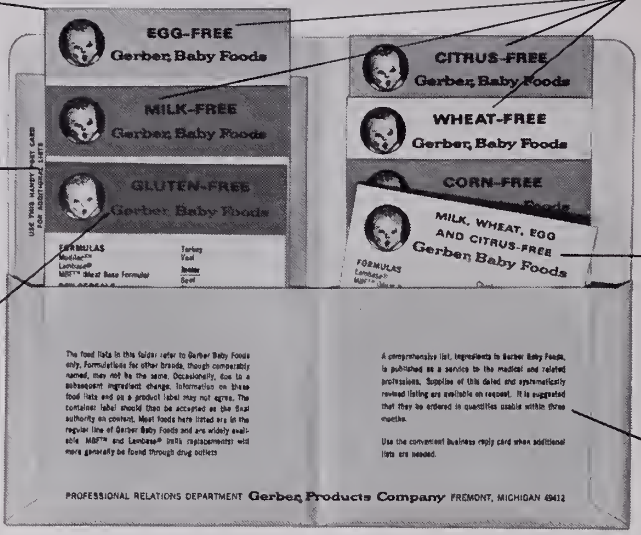
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaire by the concomitant administration of high calcium content drugs, foo and some dairy products. Treatment of streptococcal infections sho continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid Compan
Pearl River, New York

Handy packet displays all lists at a glance.

Post-paid order card for additional lists.

An individual list of gluten-free foods.



The food lists in this folder refer to Gerber Baby Foods only. Formulations for other brands, though comparably named, may not be the same. Occasionally, due to a subsequent ingredient change, information on these food lists and on a product label may not agree. The container label should then be accepted as the final authority on content. Most foods here listed are in the regular line of Gerber Baby Foods and are widely available. MBF™ and Lambase® (milk replacements) will more generally be found through drug outlets

A comprehensive list, ingredients in Gerber Baby Foods, is published as a service to the medical and related professions. Supplies of this dated and systematically revised listing are available on request. It is suggested that they be ordered in quantities usable within three months.

Use the convenient business reply card when additional lists are needed.

PROFESSIONAL RELATIONS DEPARTMENT Gerber Products Company FREMONT, MICHIGAN 49412

Separate lists of foods free from four common allergens.

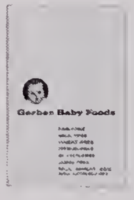
A list of foods free from milk, wheat, egg and citrus fruit.

Lists are revised frequently by Gerber nutritionists.

For the food allergic patient

Infant "Survival Kit"

Enables you to eliminate gluten, any one of five specific foods or a combination of four common allergens with ample selectivity for nutritional adequacy.



With these new Gerber food lists you can institute a variety of test diets based on strained or junior Gerber Baby Foods. All lists permit selection of a varied and nutritionally adequate diet. Even when you use Gerber foods free from the combination of milk, wheat, egg and citrus fruit, your infant patient is allowed two milk-free formulas, three different cereals, two juices and *thirty-five* Gerber strained foods. Toddlers, in addition, may receive nine fruits, five vegetables, six dinners (three are high-meat), plus a cereal-fruit combination and a dessert. A total of *twenty-seven* junior foods.

Two formulas for the milk-sensitive patient.
When using this exclusive Gerber nutrition plan, you have your choice of two superior formulas for adequate nutritional replacement of milk proteins and other nutrients: (1) Lambase,® the premodified formula containing 24.4 Gm. of lamb-based protein per quart, (2) MBF™ (Meat Base Formula, beef) the higher protein formula (27.5 Gm. per quart) that allows your choice of added carbohydrate modifier. Both are unexcelled in protein quality.

LAMBASE
MBF
Gerber
Gerber

Modilac™—a complete milk formula.
For the infant who is not sensitive to milk, Modilac, Gerber Baby Formula, supplies 21.6 Gm. of protein per quart when fed at the recommended dilution of 1:1. And, Modilac being of intermediate protein content, is not overly dilute in other essential nutrients derived from milk.

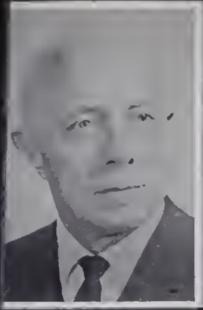
Compact and Comprehensive.
We suggest you ask your Gerber representative for your infant "Survival Kit." If you prefer, request a kit for each treatment room. It's a spacesaver and a timesaver, occupying a scant five inches on your desk and requiring less than a minute of explanation to the mother. When your supply of any list is exhausted, an additional minute allows you to complete the post-paid reorder form. Or keep in touch with your Gerber representative who will have latest revisions of all listings.

One thing to remember—these lists apply *only* to Gerber Baby Foods.

"Tomorrow in Today's Hands" . . . through Gerber Research.

Gerber Products Company,
Fremont, Michigan 49412

Gerber®



BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Through a United Voice

Have you heard the following question recently?

"Why should I belong to or be active in the AMA or MSMS?"

Perhaps you have.

I have.

And I've enjoyed discussing the question with some of the medical students, with some of the physicians under 39 and with some of those over 39. And I've had strong support from time to time from the students and from those both under or over the Jack Benny-age of 39.

My answer to the question and the supporting comments of many Michigan physicians seem to shape up this way:

> *Physicians are living in a social, economic and governmental climate which requires medicine to present the strongest, positive voice possible to state the profession's side to the hundreds of issues that are being discussed by the public, the educators, the students, the planners, the media, and the lawmakers.*

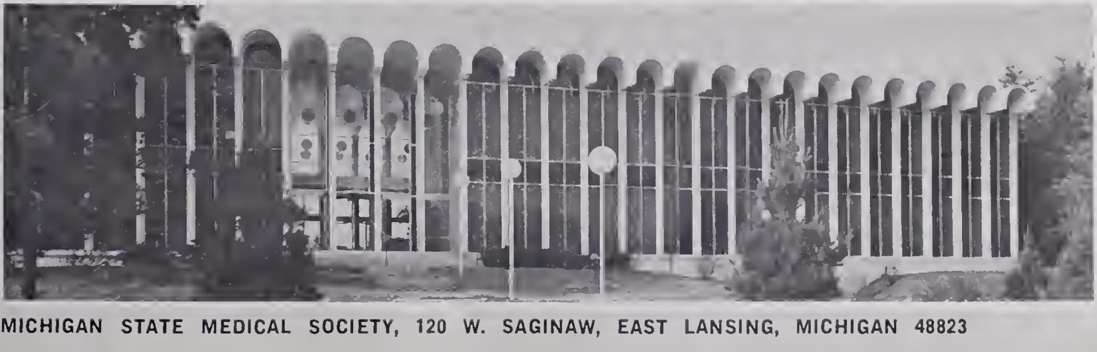
I hope you will agree with my answer, which in effect says, "in unity there is strength." Every physician through his county medical society, through MSMS, and through the AMA should raise questions and present his own point of view. He should have the opportunity to serve on committees, to strive to become an officer, to function as a delegate.

In our medical organization we must take advantage of the opportunity to debate the issues and to re-examine our philosophies. This is possible; and I hope can result in a minimum of public disagreements which dissipate the strength of our united voice, stand and action. A complete consensus is not possible; and probably not even desirable. But the issues must be studied, debated and tackled by physicians as professional men and women—well-educated and well-grounded in ethics.

We all have often repeated the famous quotation, "I disapprove of what you say, but will defend to the death you right to say it." This is my feeling too.

> *Physicians who treasure their opportunities to serve mankind and who love the profession will want to offer constructive suggestions and will work through the existing, democratic channels to bring about progressive changes.*

The AMA President, Milford O. Rouse, M.D., put many of my reactions together well in a speech recently when he said: "As physicians, we can best play our role in the continuing and increasing debate that is going on in this country regarding welfare, governmental power, and all other elements of our political, social and economic lives by working in unity, in harmony, and by focusing all our efforts into one main channel of communication through a united voice." □



MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 ye of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, di turbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reductio

Magna
cum
epression

For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

Tofrānil can often relieve the symptoms of her depression. If it can relieve her mental anguish, you may be able to help her graduate into a new and fruitful life of her own.

Tofrānil could be her commencement, too.

Tofrānil® Geigy

imipramine
hydrochloride

in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

or addition of a tranquilizer or
porary discontinuation of the drug,
eptiform seizures, orthostatic
otension and substantial blood
sure fall in hypertensive patients,
ura, transient jaundice, bone mar-
depression including agranulocy-
, sensitization and skin rash
uding photosensitization, eosino-
a, and mild withdrawal symptoms
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antiparkinsonism drugs).
patient Adult Dosage: Initially,
ng. daily, increased, if necessary,
0 or 200 mg. Maintenance dosage
be lower, 50 to 150 mg. daily, if
sible.

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Has Emergency Care Plan Been Tested?

BY BROCK E. BRUSH, MD, CHAIRMAN
MSMS PUBLIC RELATIONS COMMITTEE

"The MSMS component medical societies should take the leadership in developing an emergency medical care plan and in conducting an annual trial run."

That is a recent motion of the MSMS Committee on Public Relations that was approved by the MSMS Council, and thus routed to the 55 component societies across the state.

Many of the county medical societies have helped to develop workable patterns to provide medical care in case of any disaster. The need for an emergency plan can face any community in Michigan when we consider the growing possibilities of multiple car accidents; train, bus or airplane accidents, tornado or other weather problems; industrial mishaps; fires, etc.

The second part of the emergency care concern voiced above rates special attention. It is fine to have a plan on paper — but it is essential that the medical profession be sure that there is "an annual trial run." Some of the counties fortunately have found weaknesses in the on-the-paper-only plans, and have been able to correct them after a test.

The county medical society — because the physicians are the only ones that can provide the medical treatment that would be needed during and after an emergency — should anticipate such a situation and should gather together the appropriate agencies and persons to perfect an emergency medical care organization. The physicians will want to get the advice and involvement of the city governmental officials, communication executives, ambulance services, the scouts and other volunteer helpers, etc.

In developing a pattern, these people will want to explore all the needs for blood banks, blood substitutes, bandages and dressings, drugs, stretchers, respirators, etc. The plans for facilities should include not only the hospitals but also the school gymnasiums, military armories, etc.

To be sure that the injured will receive the right treatment and care, it would be well to select a triage officer who would decide upon the urgency of the cases and would establish priorities.

The county medical societies which have good plans already tested in 1968 can consider many related projects. One of the good complimentary activities would be for the medical society to sponsor a seminar on trauma — or a workshop on shock — and thus provide information and experience for the many ancillary people who are always needed when emergencies do arise.

Physicians are eager to provide prompt and efficient handling of every emergency victim — and the component societies must assume the responsibility of organizing the total team and testing it for functional flaws. ☐

Who Carries on Now On Manpower Report?

BY ROBERT J. MASON, M.D., CHAIRMAN
THE MSMS COUNCIL

Surely you have read many articles recently about the Report of the National Advisory Commission on Health Manpower. I certainly have.

Newspapers have picked up some of the more spectacular aspects, some social planners dismiss it as too mild, and the medical profession has approved and agreed with many of the proposals in the Report.

Today, we ask "who carries on from here?"

THE PANEL OF EXPERTS who conducted the study and wrote the Report has completed its work.

The physicians or medical profession really can't implement all the recommendations alone.

Then who should?

PERHAPS ONE PORTION of the Report itself provides a possible answer. In part the Report declares:

> *"There is a crisis in American health care. Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel. This report, therefore, deals primarily with what can and should be done now. . . .*
>
> *"At first blush, this might sound as if we are about to propose the creation of a master Federal plan for national health care. Not so. We are convinced government alone is not big enough to solve the problems of health care for the American people. Our recommendations require that the resources of each*

of these powerful forces (the professions, voluntary agencies, religious and educational institutions, hospitals, organized labor, business and industry, and concerned citizens) be applied to reshape effectively the health care system."

Maybe the suggestions are in the last sentence? If the problems of health manpower and health care must be solved, then the medical profession must be involved and must take the leadership. We cannot, however, dismiss the possible contributions by many other forces. Medicine, it seems to me, cannot ignore the potential good that a coalition of physicians, nurses, technicians, social workers, voluntary agency officials, governmental executives, and other interested parties.

AMA President-Elect Dwight Wilbur, who served as a member of the Commission, has suggested that the Report will serve as a major basis for future legislation dealing with health care.

THE OPPORTUNITIES ARE here for medicine and the individual physician to become informed about the recommendations of the Report, and to get involved in seeking solutions to the many problems facing the physician and the patient alike.

Who can really understand the problems better than physicians and actively seek workable solutions? The Report provides a framework that can be altered and modified.

Who carries on from here? ☐

AMA Legislative Challenge "Never So Formidable"

BY DONALD E. WOOD, M.D., CHAIRMAN
AMA COUNCIL ON LEGISLATIVE ACTIVITIES
INDIANAPOLIS, INDIANA

Never before has the task for the AMA Council on Legislative Activities been so formidable as it is today.

And never before has this scope of AMA activities been so strong a reason for every physician to belong to the AMA.

Under the "Great Society," a once-steady stream of 300-or-so bills has swelled into a torrent of proposed legislation that has severely challenged the energies of the Council members and their nine-member AMA staff, which includes three attorneys, one a legislative attorney permanently assigned to the Washington Office.

KEEPING TRACK OF whatever pops into the Capitol Hill legislative hopper that can have any direct or indirect bearing on the medical profession or public health long has been an obligation

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carried out by the American Medical Association on behalf of the medical profession.

Through the years this task has been performed by the AMA's Council on Legislative Activities, 13 perspicacious physicians appointed by the Board of Trustees, and its predecessors — the Bureau of Legal Medicine and Legislation and, prior to 1924, the Council on Health and Public Instruction.

ALMOST OVERNIGHT HEALTH care has been catapulted into a position of paramount national concern. The successes of American medicine have led to an increasing demand, and there has been a pervasive search for ways to obtain more health care services through legislation.

The legislative statistics clearly speak for themselves. During the 88th Congress (1963-1964), for example, the AMA Council and its staff analyzed 860 bills of medical interest. Before the 89th Congress adjourned in 1966, that record activity on health legislation was paltry in comparison. In that session attention was focused on 1,526 bills. And in the first session of the 90th Congress (1967) another 1,127 bills had gone into the hopper.

This surge of legislative activity is reason enough to again focus attention upon the roles carried out by the Council in the interests of organized medicine. Since laws are drafted by legislators and others who seldom are experts in the areas their bills seek to cover, it is imperative that the proposals be weighed and judged by those whom they would directly affect — in this case, physicians and their patients.

AS REPRESENTATIVES OF the medical profession, members of the AMA Council and their staff have the responsibility of scrutinizing each bill of medical interest, striving to determine its strengths, its weaknesses, its immediate and long-range effects, its ramifications and subtle implications, if any.

After obtaining the expert views of many interested parties, the Council makes recommendations to the Board and these, sometimes, compel the need for policy-making decisions on matters of significant import.

Matters of the greatest interest to the profession occur in broad areas affecting medical education, medical practice, construction of health or teaching facilities and provision of medical services.

To effectively present the case for or against proposed legislation expert physician and non-physician witnesses are summoned to present AMA testimony before Congressional committees and sub-committees. During the first session of the 90th Congress, the Council developed 16 statements concerned with 11 legislative proposals. Of these

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11 legislative issues, the Association favored six, opposed two and voiced partial support or opposition — or suggested an alternative approach — to the remaining three.

Even after laws are passed, the AMA Council continues to seek modifications which it deems to be in the best interest of the public and the profession. ☐

Patience, Understanding, Loyalty, and Work

BY W. G. GAMBLE, JR., M.D.,
EDITOR, BAY-ARENAC-IOSCO

One cannot afford not to participate in so-called political medicine. If one expects to avoid some of the changes that bureaucracy is imposing upon us from the state and national levels. It is our duty, each and every one of us, also the members of the Auxiliary, to extend a helping hand in advising others on health care. Fight for what you think is right but also accept the inevitable in some cases.

We cannot always afford to be "agin" everything. We must have an alternate constructive plan of our own. Hospitals all over the land are encroaching a certain amount on the practice of medicine and some of these we cannot help. To others, we should be sympathetic and to other problems we should offer constructive solutions.

It is well for us to remember that those whom you have placed in office and have appointed you on certain committees should assume these duties and feel honored. Prepare to serve in these capacities. Practicing a policy of going into a corner and sulking is of little value. In other words, if you don't play it my way, I won't play. Physicians are supposed to be intellectuals.

Unless we furnish constructive, sympathetic leadership in health care, other powers that be may step in and tomorrow may be too late. Destructive criticism of your fellow physician is lethal poison to all physicians. As there is enough sickness in our land to provide us with a comfortable living, we should extend a helping hand to each other and then help the community as a whole.

The title of this was "Patience, Understanding, Loyalty, and Work." One cannot predict a rosy future and medicine will not go on the next few years as it has gone on in the past. Give of yourself "so that the bread you have cast upon the waters may return to you ten-fold."

(Note: the above is quoted from the Bay-Arenac-Iosco Bulletin. Doctor Gamble is the editor.) ☐

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Scientific Contributions, Suggestions Welcomed

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

With the multiplicity of journals and subspecialty journals extant, one might consider the role and/or necessity of state society journals.

To many individuals the state society journals still have significant functions. These functions embrace two aspects, (1) Informational and (2) Scientific.

AT THE PRESENT time the medical profession and allied fields are in the midst of a revolution. We are buffeted by socio-politico-economic and other changes. The state society journal is the best means available of keeping our members aware of the changes and proposed changes in these spheres. With awareness of the total picture our members should be in a better position to make proper decisions and play an active role.

Similarly, we all tend to lead a rather insular existence. The state journal is a means of educating our members as to what is going on in other parts of our state, what various groups are thinking and doing, and what facilities are available in other parts of our state.

We are all aware that MSMS has committees and elected representatives who work hard in our behest, although we are not equally aware of what they are doing. The state journal is a means of disseminating information pertaining to the activities of these groups.

FROM THE SCIENTIFIC aspect the state journals have a great deal to offer. It is true, one does not expect to find the discovery of the year in a State Society Journal. Inasmuch as most members of our society have their usual scientific journals depending on their individual needs, the state society journal should give a little bit to everybody. The reader should get an insight into ob-gyn, ophthalmology, psychiatry, public health, etc. All groups should expect to get a generalized view of the total medical picture and have a better understanding of all modalities.

The scientific section should give our members an opportunity to whet their writing tools and build a bibliography.

The state journal should be a means of making people, locally and nationally, aware of the medical advantages of the area. This can boost the state medically and entice younger men to settle and practice in the state. The state journal is a place to express our pride in the medical fraternity and facilities we have.

WE INTEND TO appoint a group of associate editors hoping thereby to involve more of the universities, regional areas and subspecialty groups to make *Michigan Medicine* truly a state-wide journal.

As Scientific Editor, I welcome your scientific contributions and would be happy to have your suggestions to make *Michigan Medicine* the foremost state medical journal. ☐

MD on Hospital Boards Really a Local Issue

BY BROOKER L. MASTERS, M.D.,
CHAIRMAN, PUBLICATION COMMITTEE

Several months ago, MSMS President B. M. Harris, M.D., wrote a President's Message about the need for physicians on hospital boards of directors.

We know that the MSMS and the AMA has taken such a stand. We know too, that the recent Report of the President's National Advisory Commission on Health Manpower made the same assertion.

But this problem, to a large degree, must be tackled by physicians at the local level.

WHEN ARE WE GOING to begin to let people know that the local hospital governing board with no physician member is not soundly constituted?

The residents of the local community and the leaders who select the hospital board members would not do business with a bank that had no bankers on its board of directors.

WHY DO MOST LOCAL hospitals in Michigan — and the nation — continue to be directed by governing boards which includes no one who is qualified to operate a medical institution or to practice medicine?

Within the walls of the hospital where we practice we should be able to make our voice heard . . . within the same walls the best possible medicine must be practiced in the best possible conditions.

AGAIN I ASK, HOW can a governing board formulate hospital policies and make management decisions to provide the best possible conditions for medical care — when participation by the very individuals knowledgeable in the practice of medicine is merely advisory?

Physicians must continue to seek a voting seat on the local hospital board of managers. And physicians must find other local people willing to listen to the cold logic of the positions taken by MSMS, the AMA and the recent National Advisory Commission. ☐

Speaking of Malpractice Insurance....

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MAILBAG

(Note: The AMA News *recently reprinted a* Michigan Medicine *editorial by George H. Lowrey, M.D., about foreign doctors. The following letter was received from a foreign physician now in New York City.)*

Dear Dr. Lowrey

I would like to express my sincere appreciation for your comments regarding foregin doctor in AMA *News;* I must say this is the first time for me to know there are some reasonable people in the field of medicine.

AS you know in the other professional field ex. in the arts if you speak with accent they will consider this as an expression of elite. Please don't misunderstand that I am try to put foregin doctor as an elite. I agree 100% with you that there should not have prejudice against us. It is easy to say but it takes a great man like you to express in public.

Sincerely yours
A foreign M.D.

Recently, I had the unpleasant experience of attempting to train a new "Girl Friday" in all office procedures, and found that I learned a great deal about why secretarial paper work is so time-consuming. The time involved in completing the most frequently used insurance forms appears to be inexcusable, and probably remediable to some extent.

Blue Shield, Medicaid, and Medicare forms all involve a great deal of copying of numbers, in addition to the patient's (or subscriber's) name and address. Not only is this subject to error in transcription, but the information must be recorded on several lines, and in no relation to the order in which the name, numbers, etc. is set forth on the identification card issued to the patient. And this is all in addition to considerable medical information which may or may not have any bearing on the claim, and which may be repetitious.

I would strongly urge that the State Medical Society insist that something be done to make matters easier, for both physician and his secretary. I would propose that each patient be issued a plastic identification card, that contains all the necessary information for processing a claim, and that can be run through a franking machine like an oil company or any other credit card, onto the insurance claim form (be it Blue Shield, State, or Federal Assistance Program). This would obviously eliminate error in transcription of names and numbers, and could save 5-10 minutes per form. The identification cards should be designed so that a single franking machine would handle all kinds.

The alternative to improvement in the present system would be unpleasant: either a charge to the patient for filling out unnecessarily cumbersome forms or refusal to process them.

Mark C. Levine, M.D.
Flint

I recently read the editorial in the March, 1968 issue of the Michigan State Medical Society Journal and was pleased to see the stand the State Society is taking on the proposed four-year medical school at Michigan State University.

On behalf of all of my colleagues here I thank all of you for your support of the MSU College of Human Medicine. We look forward in the years ahead to considerable cooperation in further broadening and improving the delivery of health care to the citizens of the State of Michigan.

It has now been well over a year since the State Board of Education recommended to the Governor and to the Legislature the approval of the clinical years, but the legislative action has not yet occurred. We hope that it will come about before too long in order that we might produce more practicing M.D.'s for the citizens of our state.

Again, thank you very much.

Howard R. Neville, Provost
Michigan State University

I was impressed with the very nice February issue of the Michigan State Medical Society Journal which did a very nice job in presenting some of the problems in Viet Nam. I am sure your work has acted as a good stimulus for further thought about the medical aid situation and probably will interest physicians in volunteering. Keep up the good work.

Alfred B. Swanson, M.D.
Grand Rapids

Congratulations on the great improvements you are bringing forth in the *Michigan State Medical Journal*. The book certainly would have to rank among the top five of all the state books, if not higher.

—Russell F. Staudacher,
Executive Director
Student American Medical Association

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Don K. Alexander, M.D., 301 N. Ingalls Street, Ann Arbor, 48104
Wm. L. Beauregard, M.D., 3535 W. 13 Mile Road #606, Royal Oak, 48072
James A. Bennett, M.D., 8900 Mason, Taylor, 48180
Theodore I. Bergman, M.D., 7330 W. Seven Mile Road, Detroit, 48221
Iam P. Bhisitkul, M.D., 1 South Fifth St., Niles, 49120
Charles W. Davenport, M.D., 2311 E. Stadium Blvd., Ann Arbor, 48104
Ralph R. Edminster, M.D., Sparrow Hosp. Path. Dept., Lansing, 48902
Ali A. Eafahani, M.D., 710 Mott Foundation Bldg., Flint, 48502
Robert L. Fransway, M.D., 2785 Park Ridge Drive, Ann Arbor, 48103
George A. Gates, M.D., 3689 Frederick Drive, Ann Arbor, 48105
Wm. A. Himmelsbach, M.D., 5411 Sturgeon Creek Parkway, Midland, 48640
Joseph L. Izenstark, M.D., 3601 W. 13 Mile Road —Radiology, Royal Oak, 48072
Hilliard Jason, M.D., Olin Memorial Health Center, Michigan State University, East Lansing, 48823
Georgia A. L. Johnson, M.D., 2608 Darien Drive, Lansing, 48912
Lawrence A. LaPorte, M.D., Ford Motor Company, P. O. Box 570, Warren, 48090
Alvin Lewis, M.D., 358 Giltner Hall, MSU, East Lansing, 48823
Michael R. Linn, M.D., Medical Arts Bldg., Alma, 48801
Harry J. Loughrin, M.D., 1005 Abbott Road, East Lansing, 48823
Susan J. Patrick, M.D., 3156 N. Thomas Road, Freeland, 48623
J. F. Girard Rooks, M.D., 2002 S. State Street, St. Joseph, 49085
Donald S. Schaefer, M.D., 1324 S. Park, Kalamazoo, 49001
Frank M. Steele, M.D., 1521 Gull Road, Kalamazoo, 49001
James F. Tilden, M.D., Path.—Gratiot Community Hospital, Alma, 48801
Charles T. Vear, M.D., 252 S. Howell St., Hillsdale, 49242
Theodore Will, M.D., 314 S. Brown Street, Mt. Pleasant, 48858
Bo Sup Yun, M.D., 826 W. King St., Owosso, 48867
Amir M. Mostaghim, M.D., 2005 Roosevelt, Ypsilanti, 48197
George H. Ong, M.D., 5820 S. Twelfth St., Kalamazoo, 49001
Francis C. Pasley, M.D., 18471 Haggerty Road, Northville, 48167
Leonard J. Thill, M.D., 1332 Milliken Court, Traverse City, 49684
Francis Ivanichek, M.D., 610 N. Macomb St., Monroe, 48161
Scott B. Girard, M.D., 470 Tuttle Avenue, N.E., Grand Rapids, 49503
James W. Myers, M.D., St. Joseph Mercy Hospital, Ann Arbor, 48104
Eduardo Ortiz, M.D., Henry Ford Hospital, Detroit, 48202
Garth Schultz, M.D., 346 Woodmere Ave., S.E., Grand Rapids, 49506
John Strefling, D.O., Stephenson, 49887
William J. Bogard, M.D., Box A, Ypsilanti, 48197
Bernard J. Cahn, M.D., Detroit General Hospital, Detroit, 48226
Gregor K. Emmert, M.D., Urology, Univ. Hospital, Ann Arbor, 48104
David K. Meriney, M.D., Allergy Clinic, Univ. Hosp., Ann Arbor, 48104
Walter G. Parker, M.D., 343 S. Main Street, Ann Arbor, 48104
Mohammad Shafii, M.D., Children's Psychiatric Hosp., Ann Arbor, 48104
Tai Chung, M.D., Pontiac State Hospital, Pontiac, 48053
Ricardo A. Rivas, M.D., Pontiac State Hospital, Pontiac, 48053
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Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets–250 mg.
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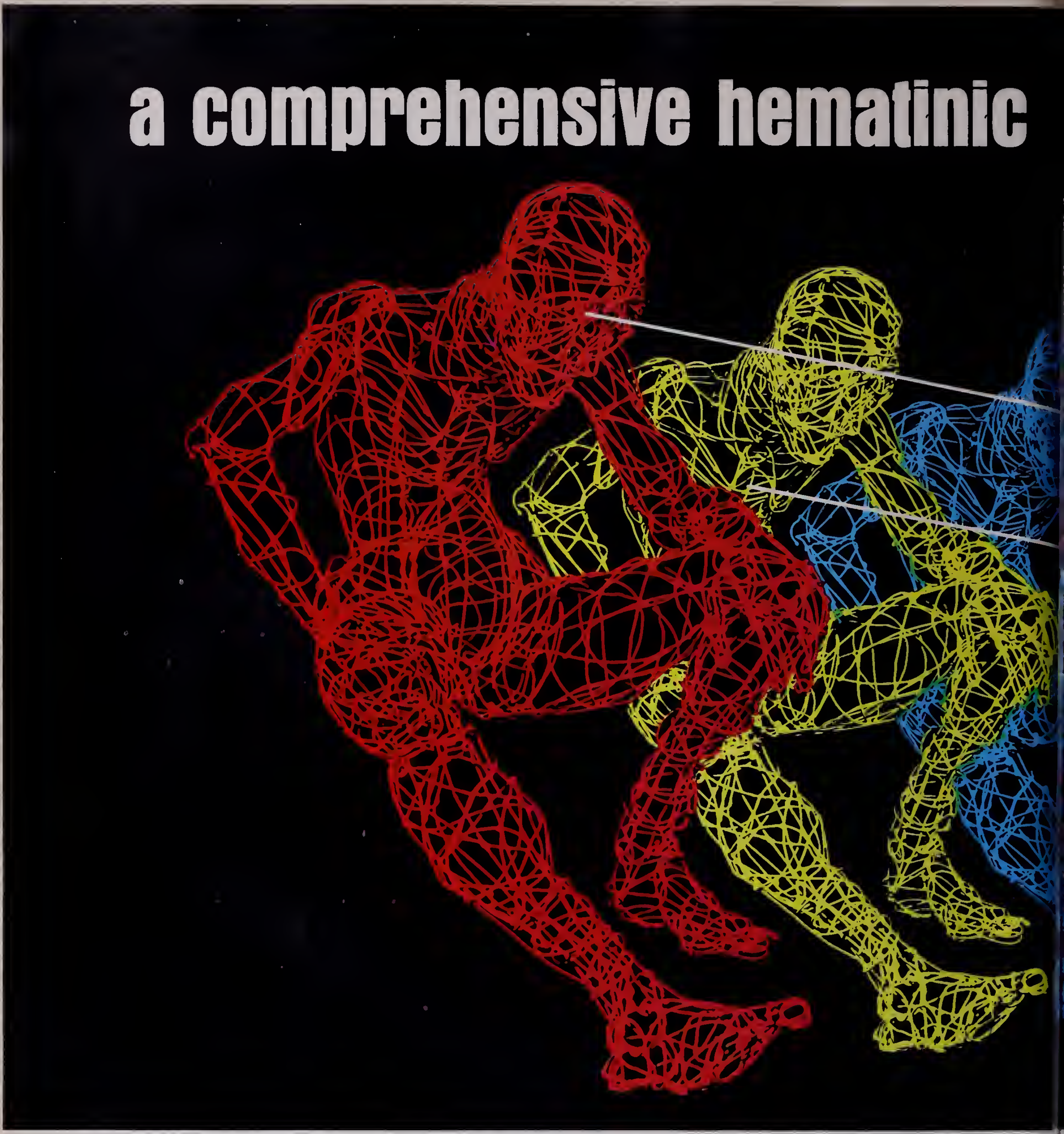

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Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, c improve the neurological changes.

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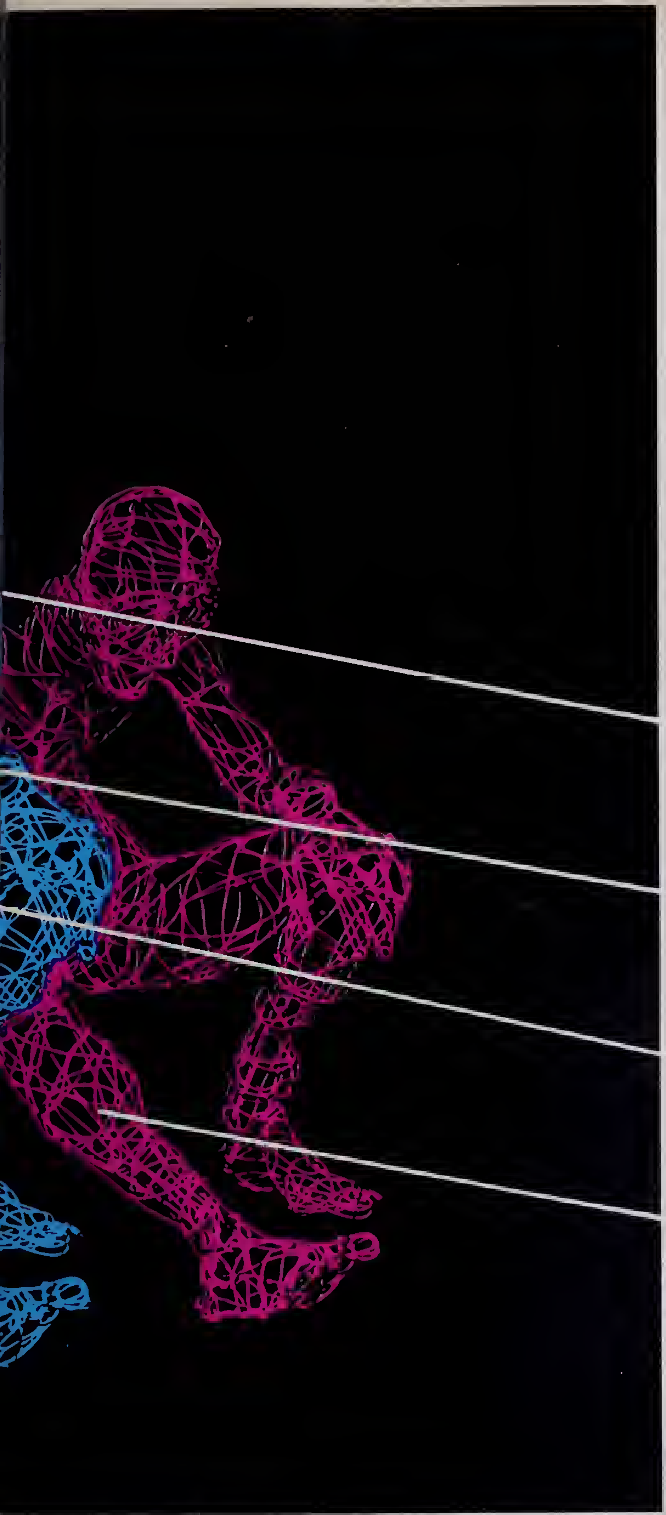

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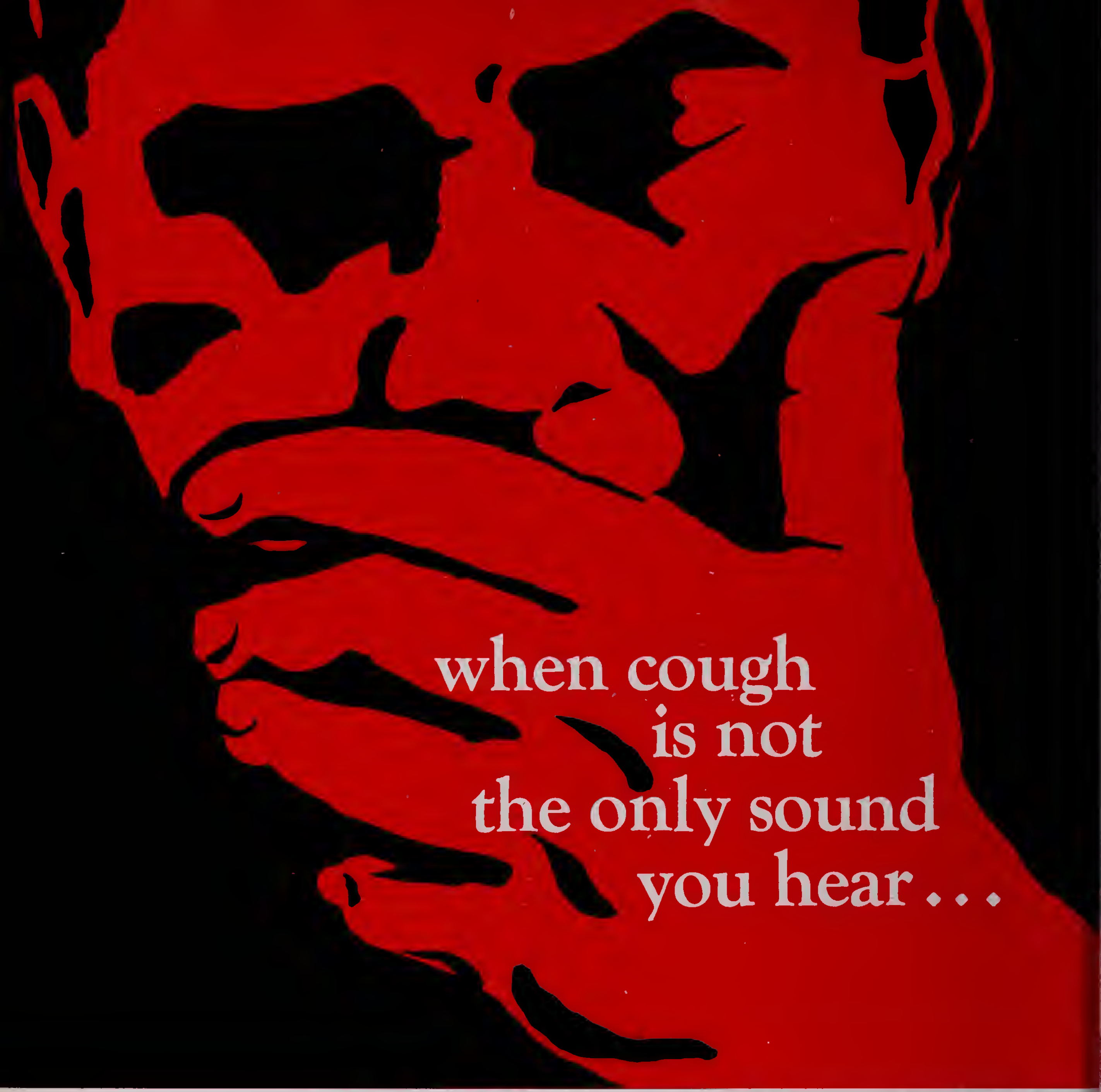

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So Drop Dead at 25

FROM LOUISVILLE COURIER-JOURNAL

(Note: The following editorial was originally carried by the Louisville Courier-Journal and understandably has been reprinted many times. We thought our MSMS members would enjoy it. —B. M. Masters, M.D.)

While the FCC is berating television for its cigarette commercials, we wish it would look into another aspect of TV ads aimed not at corrupting the youth but at demoralizing the adult. In TV commercials, nothing good happens to anyone past the age of discretion. Life not only doesn't begin at 40, it ends at 25.

Watch the people in these ads for a while. Teenagers invariably have great, glistening teeth. Adults have dentures and denture breath. Boys switch hair grease and girls are glad. Men don't have hair. If they do, it is full of dandruff.

BOYS DOUSE THEMSELVES with shaving lotion and wait to beat off the women, like traps full of cheese. Older men are happy to find something that drains all eight sinuses.

Young people have fun. Older people have nagging headaches. Young people spend all night wolfing hamburgers at amusement parks or beach parties. Older people go to a nearby movie and have to leave because their stomach is killing them. Girls have yards of blonde hair full of body and boys nuzzle it. Wives have gray hair and their husbands won't take them dancing.

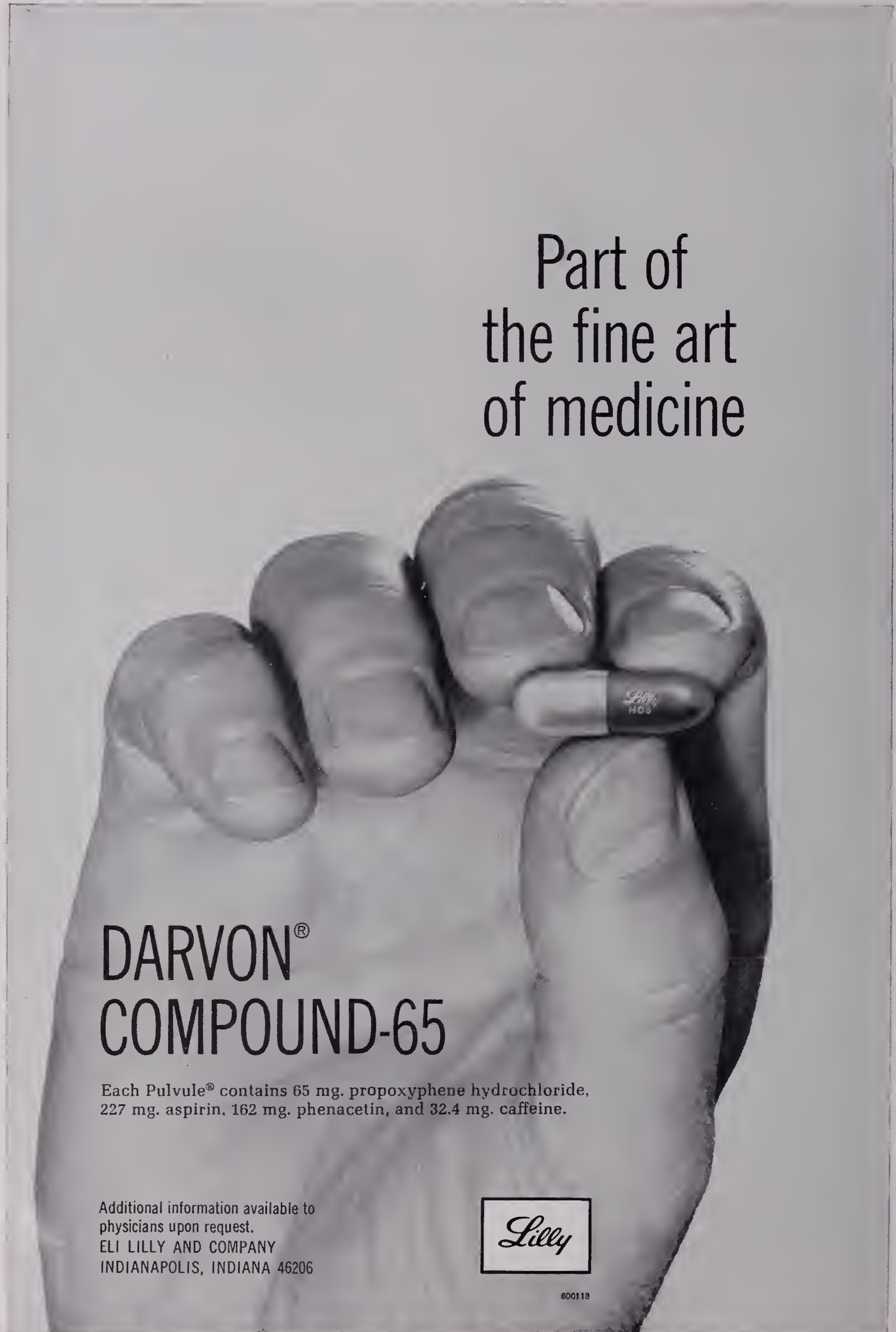
MEN WORK HARD and get ahead, only to have some pimply assistant tell them they have bad breath. The teenage wife makes a cup of coffee and turns her husband into a sex maniac. The older wife washes, irons, mops floors and puts up with birds on the sink, and her husband comes home with a miserable headache and takes it out on her. Girls are always washing their hair. Wives are always washing dishes.

Teen-agers wear sneakers and sandals. Adults wear support hose. Teen-agers rub each other with suntan oil. Adults rub each other with liniment.

ADULTS GET HAY fever and sneeze. Young people are always at the end of a glorious evening. Adults are always at the end of their rope.

Life is fun, fun, fun for the young. They can laugh even with their mouths full of hair. About the only happy time for an adult is when he has an accident and the insurance company pays off. It isn't fair!

Worse, we have a feeling that it's all too true.



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Acute Arterial Occlusion

ABSTRACT — A brief outline of the causes of acute arterial occlusion with particular emphasis given to arterial embolism. A series of cases is analyzed as to immediate results and most importantly, the prognostic significance for life expectancy after an arterial embolic episode.

BY J. A. BARSS, M.D., F.A.C.S.
PORT HURON

Acute arterial occlusion may be considered one of the true surgical emergencies. In most of these cases, the results of treatment depend on the early alleviation of the circulatory obstruction. In general an acute occlusion of an artery is caused by one of three factors: sudden *thrombosis* at an area of atherosclerosis or in a graft, *trauma,* or *embolization.* Other unusual factors, such as intra-arterial catheterization or graft kinking may occasionally produce an occlusion.

Thrombosis is always the terminal event in atherosclerotic occlusion. Usually more than 70% of the arterial lumen has been occluded before thrombosis occurs. In most of these cases symptoms of vascular insufficiency have been present in the affected extremity before the terminal event, or there has been previous arterial grafting in the area. The specific treatment of this type of occlusion requires more discussion than can be included in this presentation and has been covered widely in the literature. Accurate diagnosis is required and replacement by grafting or bypassing the occluded area are the most common methods of handling the situation. Occasionally, endarterectomy may be suitable.

INJURIES TO THE ARTERIES of the extremities have been studied extensively by DeBakey in his analysis of 2,471 cases in WWII[1], and others. The principles of treatment of these injuries are to replace blood loss, remove damaged tissue, and to re-establish arterial circulation by means of direct anastomosis or autogenous vein graft. The use of plastic prostheses is considered hazardous in the presence of possible contamination. Simple ligation of the popliteal artery resulted in 72.5% amputations in DeBakey's series, demonstrating the value of reconstructive surgery. A shotgun wound of the popliteal artery is shown in (Figure Ia), and repair by vein graft (Figure Ib).

To illustrate one of the unusual causes of arterial occlusion, we have had a case in which a dacron aortic bifurcation graft, put in under tension, one year later completely kinked both iliac limbs, requiring excision of the kinked segments and reanastomosis (Figure II). Recently, Fogarty has reported 10 cases of arterial catheterization which caused occlusion by arterial dissection and thrombosis.[2]

The main portion of this presentation will deal with arterial embolization, excluding visceral and intracranial emboli. The first successful embolectomy was performed in 1911 by Labey. Papaverine was introduced in 1934. In that same year, the use of sympathetic block was described by LeRiche and Fontaine.[3] After the later introduction of anticoagulants, the non-operative approach to arterial emboli, especially those affecting the upper extremity, was popularized. Poor results with conservative treatment, however, and the introduction of the balloon catheter by Fogarty have made surgical treatment the most effective approach to this problem. The use of low molecular weight dextran has been reported to be helpful, but is not a substitute for surgical removal of the embolus.

Our series consists of 27 emboli treated in 22 patients. (Table I.) There were 18 males and 9 females with an average age of 70. The source of the embolus in 20 cases was the heart, and in the remaining 7 the embolus came from the aorta. The emboli were located at areas of bifurcation of the arteries, most commonly the femoral.

Many of the patients had significant disease processes at the time of embolization. Severe heart disease was present in 14 patients, and 8 of these were fibrillating. Four were diabetic and 7 other serious conditions were present in the patients in this series. (Table II.)

AUTHOR

The author, Doctor Barss is in practice as a surgeon at Port Huron.

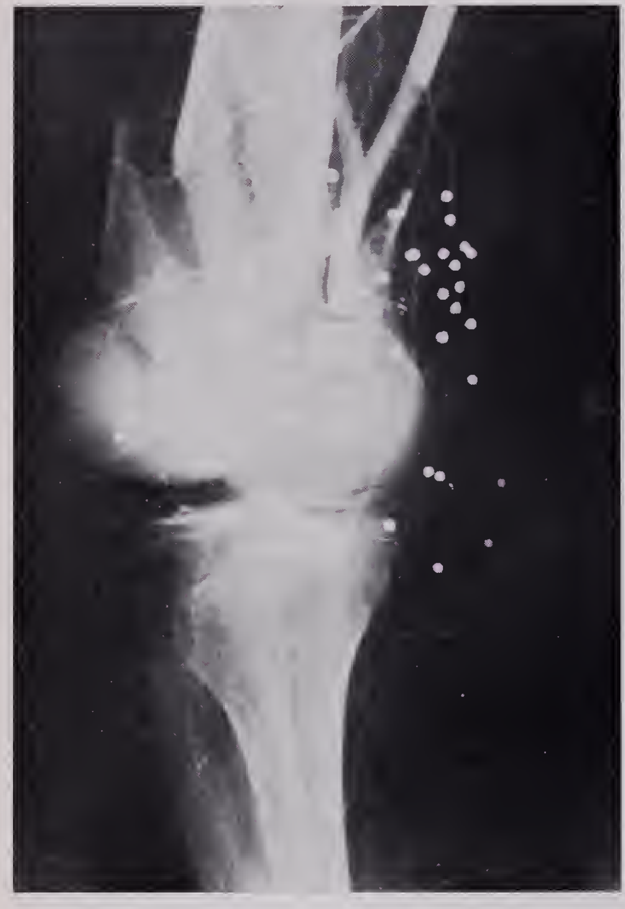

FIGURE I(a): Shotgun wound of knee, arteriogram demonstrating complete severance of popliteal artery.

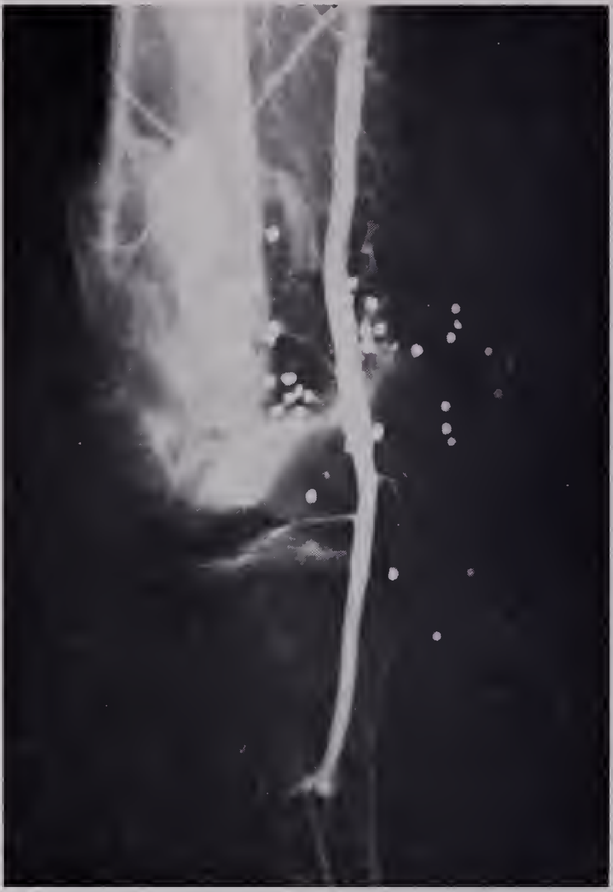

FIGURE I(b): Arteriogram six months after repair of popliteal artery using autogenous vein graft.

TABLE I ARTERIAL EMBOLI

22 PATIENTS	27 EMBOLI
18 MALE	9 FEMALE

AVERAGE AGE 70 YEARS

SOURCE OF EMBOLUS:

HEART	20
AORTA	7

LOCATION OF EMBOLUS:

FEMORAL	16
POPLITEAL	5
BRACHIAL	4
ILIAC	3

TABLE II ASSOCIATED DISEASES

SEVERE HEART DISEASE	14
FIBRILLATING	8
DIABETES	4
AORTIC ANEURYSM	3
COLON CARCINOMA	1
UREMIA	1
ADDISON'S DISEASE	1
STROKE	1
DETACHED RETINA	1
EMPHYSEMA	1

TABLE III RESULTS

RESTORED CIRCULATION	20	(74%)
HOSPITAL DEATHS	6	
AMPUTATIONS	4	

TABLE IV PROGNOSIS

OF 22 PATIENTS: DEATH WITHIN ONE YEAR AFTER FIRST EMBOLUS	10	(45%)
OF 4 CASES WHO HAD MULTIPLE EMBOLI: DEATH WITHIN ONE YEAR AFTER FIRST EMBOLUS	3	(75%)

The actual surgical removal of the embolus was successfully accomplished with restoration of arterial circulation, in 20 out of the 27 embolic episodes. (74%) Three emboli had been present over 24 hours. Two of them had poor results. (Table III.)

There were 4 patients (15% of emboli) who had amputations and 7 hospital deaths. Of our 22 patients, 10 were dead within the first year after embolectomy. Four patients had multiple episodes. Of these, 3 were dead within a year after the first embolus. (Table IV.)

DISCUSSION

The signs and symptoms of sudden arterial occlusion are well known. They include pain, coldness, and numbness in the extremity, with pallor and mottled cyanosis, usually a definite level of temperature demarcation and a loss of pulses below the level of occlusion. The final end point of viability is loss of motor function of the muscles intrinsic to the ischemic area. The results of therapy are usually dependent on early treatment, for there is always a propagation distally of thrombosis following embolization.

In large collected series of cases, 90-95% of emboli have been found to arise in the heart.[4] Most of the others arise in the aortic aneurysms or severely atherosclerotic aortas. Crane[5] has indicated that one should think of the aorta as a source of emboli in localized ischemia of one or more toes.

IN THE TREATMENT OF arterial embolism, without a doubt the most valuable recent development has been the introduction of the balloon catheter by Fogarty in 1963.[6] There has been a marked increase in successful embolectomies with the use of this catheter. In 25% of patients with embolism, other clots and emboli have been found at a distance from the original embolus.[7] Additional clots and emboli may be present even in the presence of good arterial backflow from the distal vessel. This instrument has also made it possible to remove emboli from major vessels, chiefly the iliac and the aorta, through easily accessible arteries such as the femorals. This may be done with little additional risk and often under local anesthesia. The mortality rate is high in these patients because of the many serious associated diseases, and this simple method often can be employed safely in this poor risk group.

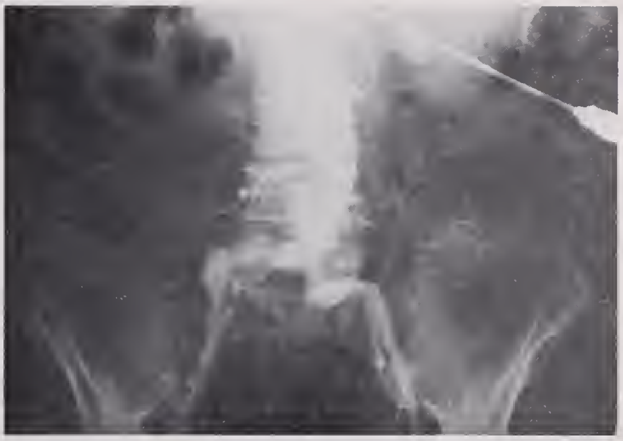

FIGURE II(a): Aortogram before aortic resection for aneurysm.

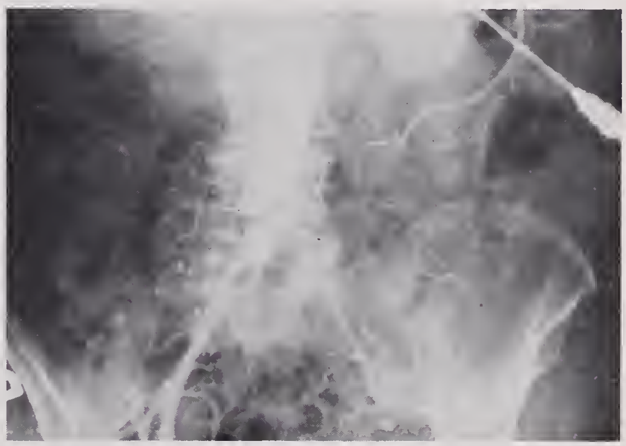

FIGURE II(b): Aortogram one year after aortic resection. Severe kink in right iliac limb of dacron prothesis is demonstrated. Left limb was completely occluded by a similar kink.

Lumbar sympathectomy has been used by us and others after unsuccessful or incomplete embolectomies in attempt to avoid or lower the level of amputation. Its main benefits lie in an improvement in viability of the skin and in some alleviation of rest pain. Most investigators agree that sympathectomy has little effect on claudication.

Anticoagulants should always be used in an attempt to prevent distal propagating thrombosis if there is to be any significant delay in the surgical treatment of acute arterial occlusion. Heparin is the drug of choice and it also used at the time of surgery because of its immediate action. We have not considered its use helpful after restoration of circulation to an extremity which had adequate outflow vessels.

MUCH WORK HAS BEEN done recently on the use of low molecular weight dextran in the treatment of vascular disease and ischemia. We have not had the opportunity to run any significant studies on the use of this material because its availability has been limited until the present year to investigation by a limited number of hospitals. Dextran of a molecular weight of about 40,000 is said to prevent thrombosis in the following ways:

(a.) It increases hemodilution and reduces viscosity.

(b.) It coats the red cells and prevents the adherence of agglutinating protein substances.

(c.) It increases the negative charge of the red blood cells and causes them to repel each other.

It has been found to be safer than anticoagulants because no defect in the clotting mechanism is produced and there is no alternative of bleeding time. Its only real danger lies in the potential overloading of the circulation.

CONCLUSIONS

We agree with the contention that surgical intervention is more effective than conservative therapy in acute arterial occlusion. Other investigators have found that even in viable limbs, after brachial artery occlusion treated only with supportive medical care, 25% have disability due to ischemia and causalgia.

Mortality rates in the treatment of acute occlusion have been quoted at from 20-40%[7] with death usually due to heart disease. Our own mortality rate was 26% with 45% of patients dead within a year following their first embolic episode. In those with multiple emboli, 75% were dead within a year after their first embolus.

The Fogarty catheter has been an indispensible addition to the surgical treatment of arterial embolism and thrombosis. Other new developments, such as low molecular weight dextran, may help to lower mortality and morbidity.

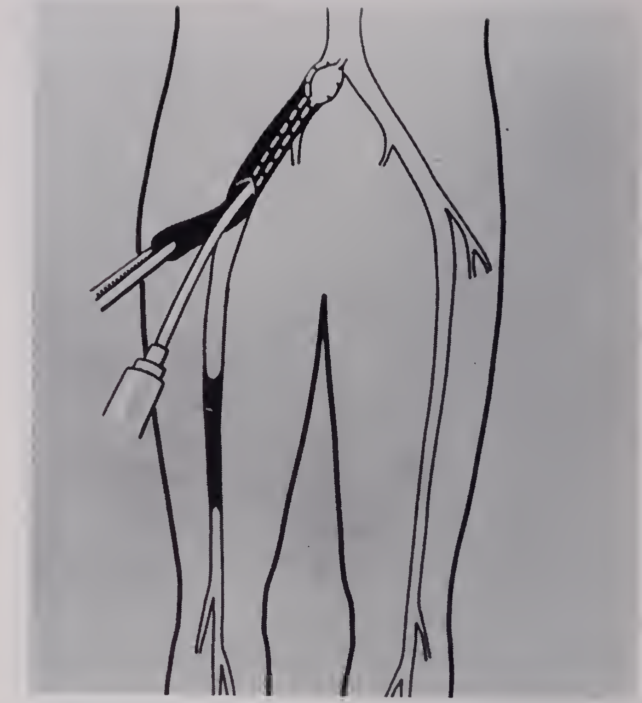

FIGURE III: Diagram illustrating the use of embolectomy catheter for extracting proximal and distal emboli through easily accessible arteries.

SUMMARY

A review of 27 emboli treated in 22 patients has been presented, along with a review of the causes and treatment of acute arterial occlusion.

Most of these patients have severe heart disease and/or other significant disabilities at the time of their occlusion, resulting in a high mortality rate.

Almost half of our patients with arterial embolism were dead within one year after their first episode.

Surgical treatment, with the use of the balloon catheter and other adjunctive measures, is to be preferred rather than conservative management in acute arterial occlusion.

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Editorial Comment:

This article acutely points out the value of surgical intervention in acute arterial occlusion as a limb or life saving procedure, and the obvious value of the Fogarty catheter. It is also obvious the question of sympathectomy has not yet been laid to rest.

One notes that in this group (average age 70 years) of 22 patients with 27 emboli, that a 45% mortality occured within one year. It is also noted that 14 cases had severe heart disease and 8 of these were fibrillating. One wonders whether long-term anticoagulation was used and whether it would have altered the picture.

— John W. Moses, M.D.
Scientific Editor

The Child's Call for Help

ABSTRACT — Clinical examples are utilized to demonstrate how the child calls for help in non-verbal behavioral ways, and further, in ways that are counter to what is acceptable in a given community. The examples have one important aspect in common in that they each tended to force intervention by some outside agency. The need for a community to be alert to such calls and respond promptly, thereby hopefully helping the child avoid the need for "louder" and more forceful and often more dangerous communications, cannot be emphasized too strongly.

BY RAYMOND W. WAGGONER, JR., M.D.
MARSHALL SHEARER, M.D.
BOTH OF ANN ARBOR

A suicide act in an adult is seen as a composite of the impulses to die, to be rescued, to "hurt" another person usually a "loved one," and a call for help. If the likelihood of death resulting from the act is small, it is usually referred to as a suicide gesture, with the "wish for help" impulse being predominant. These adults use this non-verbal means of obtaining help even though they frequently know how to obtain help otherwise.

What is a child to do who lacks such knowledge and sophistication, who finds himself in an intolerable situation with himself and his parents?

How does he call for help?

In our experience it is only at age 14 to 15 that a child can verbally ask his parents, teacher or other adult to secure help for him. Prior to that age he may not have the awareness that any outside agency or person could midify his and his parents interaction, or he is too scared to articulate the problem or cannot do so — perhaps even to himself.

Children must "call for help" in non-verbal behavioral ways. This may take a variety of forms.

IT IS THE THESIS of this paper that the child calls for help in non-verbal behavioral ways and this behavior is most apt to take the form of a community "delinquent" act. At least this is where we have seen it most clearly and most often.

We are not suggesting that all delinquent acts are such calls although they may be, nor are we suggesting that when the call for help is present that there is not also the comprised impulses to direct anger both to the self and to a "loved one." Although this complex is sometimes present and can be seen in some of our case material, we wish in this paper to direct ourselves to the aspect that tends to force interventions by some outside agency. We wish to emphasize the need for the appropriate helping professions to be alert for a behavioral call for help and respond promptly, thereby hopefully precluding the need for the child to attempt "louder" and more forceful and often more dangerous communications.

The cases we see are those in which neither the family nor the school have heard the call and responded appropriately, but have tended to ignore the problem or deal with it by suppression of the overt behavior.

Unfortunately, the child does not know what his community considers a psychiatric emergency (if, in fact, he has any concept of what a psychiatrist is). There is some evidence to indicate that the older child's concept of what constitutes a psychiatric emergency influences his choice of behavior. For example one 12-year-old boy wrote numerous suicide notes and acted depressed. He talked of committing suicide by drowning and once while at the lake said to his parents, "I'm going to walk right out into the lake until it's over my head and keep walking." He did so and was rescued by the lifeguard who pulled him into a rowboat. It was only after he had subsequently announced that he was going to walk in front of a car and did so that his parents sought psychiatric help.

DELINQUENCY IS THE most frequent method chosen by children to gain outside intervention. The single most frequent delinquent act is to steal in a manner to insure apprehension. Stealing is often easy for the child to rationalize. There is relatively little risk of self-injury and other motives can frequently be achieved. One 12-year old boy stole a $200 necklace while baby-sitting and gave it to his girlfriend to "wear to school" where he knew it would be spotted. Auto theft is also common:

A. IS A 16-YEAR-OLD BOY who had been in several foster homes until he was adopted at the age of 9. He came to the attention of the juvenile court after he had stolen a car, driven it around with a friend and then pushed it in the river. When A. was interviewed he appeared as a tall, thin, nice-looking boy who looked considerably younger than his 16 years. He had a drawn, tense, depressed appearance and his eyes looked as though he might be about to cry. He was quite anxious throughout the interview.

When asked what had happened, he started by saying he could no longer live at his home, that he had to get out because he could not get along with his father. He then said he and a friend had seen a car with the keys in it, gone for a joy ride, parked it that evening and left it. He said he felt certain the police would find it but they did not. He and his friend went back the next day and after driving around some more, and since they had not been caught yet, they felt they ought to push the car in the river. Apparently, someone had seen and recognized A., and had reported it to the police so he was later apprehended.

A. said he did not know why he had taken the car, but when asked about home he again said he had to get out. When asked what might happen if he was returned home, he said "Oh, I might try to rob a gas station or something like that." This was said with a considerable amount of anxiety and was taken as a sincere statement.

The evaluation of the family revealed that the boy's mother had some 15 years ago lost a baby at 3 weeks of age which was to be her only pregnancy. She apparently suffered a severe depression at that time and has clearly never worked through her grief. As she talked about the loss, she became extremely agitated and depressed and her facial expressions denoted intense rage. What became apparent was that she was in effect, attempting to replace her loss with the adoption of A. and attempting to psychologically force him into an infant's role. The situation had become intolerable for A. who in a joint interview with his parents seemed unconsciously and ambivalently trying to be the infant his mother was wanting him to be. In this interview the mother clearly demonstrated that she was totally unable to "hear" A. or respond to his emotional needs.

At the time of the theft, it is unlikely that A. consciously was aware of why he stole the car or for that matter pushed it in the river. Following his apprehension, detention in the Juvenile Detention Home and psychiatric evaluation, however, he was to some degree aware of the implications of his actions. This seemed clear by his statement about robbing a gas station if he were returned home. Interestingly, on a previous occasion some months before, he had written his name on a water tower in a nearby city "because I wanted to see my name writ like that."

There appears to be a strong element of guilt operative in this boy associated with not living up to his mother's expectations. He clearly has attempted to be his mother's grieved, lost "baby" without success. He has repeatedly gotten the message from his parents that in his mother's words, "We hoped he would develop meaningful object relationships but we were wrong." He was at once terribly angry yet needful of his parents. This particular act got him out of the home by being caught for doing "something bad."

In many respects, A., is similar to the adult who feels guilty and seeks punishment by doing something else for which he will be punished, and this is frequently compromized with the hostile wishes toward an ambivalent object, just as occurs in suicide acts.

The following two cases demonstrate this further.

A 7-YEAR-OLD CAUCASIAN boy was referred to Children's Psychiatric Hospital by a child guidance clinic, secondary to referral to them by the police. The chief complaints were lying, stealing, fights, fire-setting, enuresis, belligerance, yelling at mother (I hate you) and calling her a tramp and a slut like his father did. The incident which precipitated the referral was his pulling a knife on the babysitter. (Three years prior to the incident the mother had a "nervous breakdown" and picked up knives and threatened to kill people.) The mother stated he had a bravado, belligerant attitude and repeatedly said, "I don't have to listen to you. I hate you." She reported that she was at her wits end to know how to control him. She had tried to manage him by talking to him and had whipped him with a belt, sometimes on his bare bottom.

He was quite close to his maternal grandmother prior to her developing leukemia and dying in 1966. The parents date the onset of his difficulties to about six months prior to her death which coincides with her lethargy and the diagnosis of leukemia being made.

The mother, age 29, was three months pregnant with the patient prior to her marriage. In 1964 she had a "nervous breakdown" resulting in a series of ECT. Subsequently, she has had three addtional psychiatric hospitalizations for "going to pieces." One of these was secondary to an overdose of sleeping pills. In terms of modesty, the mother stated she does not go out of her way not to be naked in front of the children and that when she does walk into a room naked she tries to convey a nonchalant attitude so the children will not think there is anything to be ashamed of.

The father, a 31-year-old electrician, was married previously. His first wife committed suicide with an overdose of sleeping pills in June prior to his marriage to his current wife in November of the same year. He also attempted suicide with sleeping pills shortly after his first wife's death. He noted their son did not play with fire or soil his pants when around him. Except for enuresis and encopresis the boy is just like his father was as a child, according to his father. The father also would go around the house naked, including standing in front of the picture window, which his wife objected to. He replied that passersby do not have to look if they do not want to. This decreased after the police talked to him about it. At the child guidance clinic, the parents got into a real argument as to whether she had filed for divorce six or seven times. Each parent would "steal" from the other and from the children's banks. The wife took the hinges off his gun cabinet to take 27 silver dollars to pay her Bingo gambling debts. Both also tacitly acknowledged they stole from outside the home also. On occasion the mother would tell the children the father stole the plywood in order to make some favorite toy. Each accused the other of infidelity in front of the children without the other denying it. The patient picked up the mother's accusation of the father sleeping with the "girl next door." He also imitated his father who called his wife a tramp and slut after she was "raped" when she was picked up by a man while walking along a highway. After the rape she coaxed the man to take her to a drug store — where she called the police.

There are two other children, 2 and 4½ years younger.

A school report indicated that the stealing was chiefly a means of getting attention, that his teacher was completely rejecting him. The trait that got to her most was "that silly smile he wears all the time, especially when confronted with his stealing." He was at grade level, doing "C" work. He has a normal attention span and does good seat work.

Psychological testing revealed a guarded, rather than constricted boy who could modulate this tendency in the service of attaining his goals. He lacked flexibility under stress. "It was not possible to state precisely the source of this lack of depth in adaptive skill. One might suspect a very limited experience basis, a deprivation along these lines in the home situation." "In content the tests suggested an incomplete resolution of the first phase of the oedipal complex in rising sexual curiosity. What was suggested was no regression but slowed psychosexual development. He had many concerns about his body and that of others, but this was more curiosity than fear of injury. He pictured home life as disorganized. He was aware of parental struggles, felt helpless, sided with mother but saw her as helpless. She was seen as potentially giving but not doing so. There was a considerable defense structure against the aggression of father."

He responded very positively to a description of the type of hospital CPH was and was eager to explore the hospital.

It appeared that, indeed, he got a great deal of nurturance from his grandmother prior to her illness and that a good deal of his behavior constituted an imitation of his parents, as he was caught in a real conflict between his warring parents. This state was chronic. The call for help was his pulling a knife on the babysitter.

M. IS A 13-YEAR-OLD, handsome, slightly overweight boy of superior intelligence who was referred to CPH by a psychiatrist because of refusal to go to school and repeated physical attacks on his mother during which he had inflicted painful bruises, and due to his apparent lack of control and evident rage, had quite frightened his mother. This had gone on for about two months prior to referral to CPH.

His 17-year-old brother had to intervene on more than one occasion to prevent serious physical injury to his mother. The boy's parents are divorced and at the time he was seen — the boy was temporarily living with his father because of the family's concern of injury to the mother.

M. had done well in school and had shown no overt evidence of conflict until approximately one year prior to referral. At that time he began refusing to go to school because of "stomach aches." (Interestingly, the mother had a 15-year history of colitis with frequent complaints of abdominal cramps.) He would then stay home on some occasions or on others return from school after calling his mother to pick him up.

This developed to the point where he entirely refused to go to school. Pressure from the school resulted in a number of examinations by physicians over the year, including four psychiatrists. Attempts to physically force him to school resulted on one occasion in the father being kicked by M. in the testicles which promptly halted these efforts. After that he would sit at home watching T.V., help his mother with housework, prepare dinner and help with washing the dishes after dinner.

Frequently he would go to his mother's bedroom after she had gone to bed either to have his back rubbed or to rub his mother's back. He noted his mother was a very neat housekeeper except that "her room is always a mess." He had often slept in his mother's bed since his parent's separation and subsequent divorce (this had occurred some five years prior to the evaluation). It finally developed that if his mother would attempt to keep him out of the bedroom on the recommendation of the physicians she had seen, he would become violently angry, kick at the door, try to force his way in and it was usually at these times that the attacks on his mother would occur. The mother noted that she had been told he was suffering from an "Oedipal complex and I should completely reject him."

The parents had had marital conflict for a number of years and were divorced as was mentioned above, five years prior to referral to our clinic. M. had lived with his mother since the divorce and was visited two to three times a week by his father. The mother was seen as a very angry, depreciating woman who showed a high level of anxiety and what appeared to be a chronic depressive state. She had marked dependency needs which she was unable to get fulfilled. After her husband left, she allowed M. in essence, to take his father's place, often allowing and encouraging him to sleep with her at night. Neither M. nor his mother were able to handle his impulses as he moved into puberty.

At the time of evaluation, it became clear that the situation existing between the mother and M. was of crisis proportion and that immediate intervention in the form of removal of M. from the mother's home was essential to prevent serious injury to the mother.

The question of conscious versus unconscious motivation in these patients should be mentioned. Usually there seems to be some conscious awareness or at least a preconscious awareness of what the symptom is accomplishing by the time of psychiatric referral.

The following is a case history of a "second" call for help when the first resulted in treatment which did not meet the child's needs or expectations. The unusual feature here was the child's awareness of available help and what the child guidance clinic would consider as emergent for the second call. This was apparently due to her knowledge of her father's duties in religious work. It is felt her "second call" was conscious and deliberate.

W. IS AN 11-YEAR-OLD white female, referred to CPH from a child guidance clinic with the chief complaint of delusions. She had been refer-

SHEARER

CO-AUTHORS

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red to CPH from a child guidance clinic with the viously by her mother with the chief complaint of, "she has no friends."

Both parents are middle age and college graduates. The father is employed full time in religious work (not a minister). Many evenings and weekends he is not available to his family. He gets "kicks" out of outmaneuvering other drivers in traffic and running red lights. He does not follow many teachings of his church in daily living, although he professed to do so. He intellectualizes frequently. The mother described her own childhood as one of conflict with her own mother — "Mother never said what she really meant." The patient and her mother occupied the same position in their respective sibship.

The patient's early developmental history was unremarkable except for difficulty in toilet training and stubborness.

At the child guidance clinic, beneath the veneer of a mother seeking help for her friendless daughter, was a hostile mother who spoke of the patient through clenched teeth. The patient had a mind of her own, would not obey (i.e. coming home from school a half hour late, refusing to help around the house, not taking piano lessons). The mother complained that the patient sang off key, "She is obese and our doctor doesn't like fat kids. She has no poise or social grace. She walks and looks like her father." (Mother was a Girl Scout leader and said the patient had no friends among the Scouts.) Compared with her talented, gracious, achieving sisters, she was second best although an A-B student. Her dress and general appearance was more appropriate for an 8-year-old than a girl of 11.

She was wearing her Sunday clothes on a Friday (which the parents said was "intolerable"), was poorly groomed especially in church, had taken to making facial grimaces in church, and picking her nose and eating it at home and in church. Lastly, she had begun to talk of death, dying and running away.

On investigation, she did have friends. Most of them were boys and her play was tomboyish.

At the child guidance clinic things got worse after a brief time. Her drawing shifted to only heads of women and boys with skirts. She began exposing her panties in the office and at length talking about a snake in the filing cabinet that was going to bite her, and saying she could talk to God. She said God told her his real birthday was December 13, and he was coming in the year 200—a fact she was to publicize. The child guidance clinic became quite alarmed and referred her to CPH for inpatient treatment.

At the time of referral she was seen to be depressed. She also had an extensive fantasy life with some question of her control of it. Her two fantasy themes were being a deserted waif and rescued by a prince charming and of people being secret agents to spy and find out what others thought of her and report to her. By the end of the interview she was relating quite well.

The mother was relieved at the recommendation of inpatient hospitalization.

On admission, she carried a small jewelry box with a small piece of yarn protruding. It was her "transistor" which allowed her to talk with the "Jolly Green Giant" and with "God." She was about to leave this in the doctor's office when her mother reminded her of it.

The first progress note was written after one and a half weeks. "The patient impresses me as anything but a psychotic youngster and I am hard put to believe she is actually hallucinating or delusional, even in the past. Rather, I feel that she has used her pseudo-delusions as manipulative devices to restructure and influence her environment and this to a great success. She indicates that she was eager to terminate her relationship at the child guidance clinic because the hope for changes in the relationship with her parents was not forthcoming. At this point, even knowing or sensing her therapist's sensitivity to this particular kind of behavior or production, she (best as I can tell) feigned hallucinatory and delusional experiences in order to sever the relationship. She was successful in doing this. In spite of her verbal protests and playing the role of not liking it here at CPH, it is rather obvious she is enjoying her involvement in her activities with me." She does grimace at time and her attitude toward feminine staff varied from normal to one of stubborn rebellion or infantile clinging.

Later the basic dynamics emerged. The mother was quite ambivalent toward the patient's emerging sexuality. On one hand, mother was fearful her daughter would be too attractive to boys and act out sexually, hence the clothes inappropriate for her age and general parental attitudes and restrictions commensurate with that younger age.

On the other hand, in subtle, undoubtedly unconscious ways, she was encouraging her daughter to act older than her age. The parents had a poor sexual relationship and the mother was seen as having a "super ego lacunae" in the sexual area with the fear of her daughter's sexual involvement yet vicariously enjoying the thought of it.

THE CASES THAT we have seen have a long history of chronic conflict between the child and usually one parent with the other parent either being psychologically not involved or supportive of the conflict in indirect ways. The child may, in fact, be acting out the parent's unconscious needs. At the time of a clear "call for help" this chronic conflict usually has taken the turn for the worse, which though not necessarily too marked, is obviously significant if recognized. There is, of course, the new symptom or behavior which constitutes the call for help also.

Often when the child is interviewed alone he has more insight than his parents and is greatly relieved at the intervention and especially at the prospect of treatment.

The denial one sees in parents in these situations is usually considerable and must be dealt with actively and directly. Sometimes the goal in regard to the parents, that must be settled for is helping the child understand his responsibility and part in what is happening and to guide him to make the best possible adjustment to a difficult home situation.

In this paper we are not suggesting that all deviant behavior is an unconscious call for help. What we are proposing is that there is a group of cases in which the symptomotology is based on the child's unconscious or almost conscious desire for help.

We also feel there are implications for treatment, establishing a meaningful rapport with the family at the time of the first contact, but most important is heeding the call the first time, wherever the call arises so that the child is not pushed to even greater and more dangerous measures to attract and sometimes force outside intervention and assistance.

Survival Patterns for Small Hospitals —Dilemmas and Prospects

BY ANDREW PATTULLO, M.B.A.
BATTLE CREEK

This opportunity to discuss the future of smaller hospitals is very gratifying. One reason has to do with the Kellogg Foundation and its earlier history. For its first 10-15 years of existence (1930-1945), the Foundation was primarily known in the hospital field for its activities with smaller hospitals in Michigan. In the "Michigan Community Health Project," the Foundation worked extensively in seven predominately rural counties of Southwestern Michigan and dealing with all aspects of health—preventive and curative.

It soon became obvious that hospitals were essential to this total program, but the resources at that time were rather minimal. For example, several hospitals were situated in converted "mansions." As Graham Davis, the Foundation's first hospital staff person used to say, the hospitals were "pretty sorry." Hence, the Foundation endeavored to help in many ways, ranging from support for completely new, "model" hospitals, to broad educational programs. As a matter of fact, one of the first non-metropolitan hospital councils in the country emerged from that program, the Southwest Michigan Hospital Council, noted for progressiveness and its sponsorship of the Professional Activities Study.

At that time (circa 1940) a considerable controversy raged in this country concerning the role of small hospitals. (And times haven't changed too much.) The question primarily hinged on "to be or not to be." A number of knowledgeable people maintained that is was much better to concentrate hospitals in fairly large communities, and not to build facilities in rural areas. The Foundation's position was substantially to the opposite pole, that in fact hospitals were essential to the attraction of physicians.

Several of the model hospitals the Foundation helped to construct were in collaboration with the Public Works Administration, a federal program designed to combat the depression. In 1940, the magazine *Hospitals* carried a lead article attacking the government and the Foundation for the development of such hospitals, maintaining they were a disservice to the American people.

SOME YEARS LATER in the mid-40's there still existed a real gap between many smaller hospitals as contrasted to sister institutions in larger cities. At that point, the Foundation extended a program in diagnostic services improvement initiated in Southwestern Michigan to the balance of the state, including the Upper Peninsula, where in 1946 there was not a single pathologist and only one radiologist to serve this large region.

I shall never forget one experience in a prosperous county-seat hospital when the board President was showing me around. With some pride he opened a door saying, "This is our X-ray Department." It opened into a closet containing a portable X-ray machine. Incidentally, today this is now a fully accredited hospital of some 150 beds, beautifully staffed and equipped. The original rationale of Hill-Burton was to bring improved hospital care to rural America. It is now generally acknowledged that the Act really went too far, since undoubtedly in some states too many hospitals were built in locations where they probably shouldn't have been. And yet, readily admitting these deficiencies, Hill-Burton put the small hospital "in the sun."

Because of a massive and unique federal program, the existence of the small hospital in this country is no longer a theoretical matter. There are literally thousands. But even so, the role of the small hospital is still very much a matter of concern.

Small Hospitals Have Major Problems

Using such criteria as Productivity, Costs, and Quality, small hospitals have major problems, probably more so than in much larger institutions. For example, there is still a significant gap in terms of meeting accreditation standards of the Joint Commission. There is a definite correlation between size and accreditation — the smaller the institution the less likelihood of accreditation.

The small hospital has often been the target of charges that it is basically an uneconomical and inefficient operation. This thesis probably stands up better in the case of small hospitals in urban

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areas, where the desirable minimum size is generally looked upon as being 200 beds. In cities, the small institution is difficult to defend on the basis of plant and service duplication. But in many instances the small hospital is a single institution serving a community and surrounding area. Two hundred beds may or may not be desirable, but in most cases it is somewhat theoretical.

STILL ANOTHER CONSEQUENTIAL problem confronting small hospitals is manpower. As noted, most such hospitals are in non-metropolitan areas, and of course are not teaching institutions. Hence the attracting of skilled personnel is usually troublesome.

In 1967, as in previous years, the smaller hospital is under attack. The title of this presentation "Survival Patterns" is good proof of this. There have been dramatic changes in the small hospital over the past two decades. But there are still basic weaknesses inherent in the small hospital which must be resolved. "Survival Patterns" is a provocative way of putting it. Any examination of recent events reveals a deep concern about the community hospital.

One evidence of this is found in the DeBakey report, in turn followed by the Heart, Stroke, and Cancer legislation. The thrust of this report and Act has to do basically with the "performance gap" between the excellence in the great teaching medical centers (as exemplified by the *Ladies Home Journal's* "ten best") and something less presumably found in most other institutions. Although there may be some skepticism in terms of the actual implementation of Heart, Cancer, and Stroke, as resulting in the "haves" getting even more, the objectives are quite different—the "have nots" are supposed to benefit too.

Another compelling indication is found in hospital areawide planning, and now also in comprehensive health care legislation. Although areawide planning may have had its genesis in terms of self-protection on the part of major groups and corporate givers in such major population centers as New York, Chicago, and Detroit, its implications soon out ran this orientation. At this point no one can prophesize the total impact of comprehensive planning, but it is bound to influence the small hospital. How could it do other, since the hospital is the keystone of community health services, and the small hospital is at least numerically far in the majority?

STILL ANOTHER POWERFUL factor in the situation is the physician, at least in terms of the quality gap. Twenty-five years ago we were talking about the necessity of the hospital in smaller communities as essential to the attracting of doctors. Today the doctor who has been attracted is more and more insistent that to the greatest extent possible he not be isolated, that he have available services reasonably compared to the medical center where he was trained. This is why he wants an intensive care unit, and today, even in a 40-bed hospital, talks about a coronary care service and an image amplifier in X-ray. Sometimes these demands may not appear to be too practical, but they are symptomatic of a very real desire of the physician to be provided with what he believes to be essentials.

A generation ago the small hospital medical staff was much more apt to be satisfied with what was available. For example, the absence of even minimal diagnostic X-ray and laboratory tools was accepted, perhaps with resignation, as a fact of life in rural practice. Today's young doctor is not going to accept it.

Still another dimension is administration, admittedly an aspect of some sensitivity and delicacy. A generation ago the typical small hospital administrator was a nurse, who was usually moved up from a clinical supervisory position. Most of these nurse-administrators were sincere, hard-working, and "dedicated," as overworked as this cliche may be. A number were also efficient, able, and "hardheaded" business-wise.

In the mid-1940's hospital administration was becoming recognized as a profession; and several university graduate programs were being established. Inevitably this has had an influence upon the small hospital. Today the nurse-administrator is almost a rarity; the male is predominant. The typical board of trustees recognizes the hospital as a complex undertaking and now looks for a "business" type of executive. And more often the new breed is likely to be a young university course product, who usually views the small hospital as a first rung up the ladder.

This administrator is something like the young M.D.—he, too, wants an institution of excellence. Through regional and state hospital meetings and the other ways he keeps in touch with developments—he is not as isolated as his predecessor of 1930-1940. Selfishly, in terms of his own career, he must be associated with a hospital that is accredited. He is looking for better solutions to the problems of the small hospital. And my observation is that although he originally looked upon his job and hospital as a stepping-stone, he finds so much satisfaction he is tending to remain and grow with the hospital.

WITH ALL THESE factors—such as Hill-Burton, areawide and comprehensive health planning, medical staff, and administration—the small hospital of today is much different. But we are on the threshhold of still further changes that will be even more consequential in the coming decade.

To accomplish these, some degree of "autonomy" of the individual hospital will be lost, but I believe the new era will be one of real excitement and challenge. It will require a degree of cooperation not yet realized in the hospital field, but it will result in a very much improved level of service to the people.

"Compact" Agreements. Only within the past 20 years have state hospital associations come into their own. Within that span most states have retained full-time executives, and many have mounted imaginative and extensive programs. In the next decade we shall see similar developments on a regional level but with a somewhat different orientation. Present hospital "councils," often a pleasant luncheon club, will retain full-time executives and staffs. The program emphasis will be concerned with the development of what I will term "compacts," to which member hospitals may or may not subscribe. The trust of such compacts may be described simply as providing on a cooperative basis such services as an individual hospital would find it very difficult to undertake alone. Following are examples:

Computer Applications. The hospital world is on the threshhold of significant breakthroughs in terms of computer applications. At this point they are still very much developmental, but the potential is there. As I grasp it, if any two factors about computers are accepted they relate to (1) size of capability in terms of output, and (2) to the fact even the simpler applications are extremely expensive to implement. There is every reason to believe it would be very much to the individual hospital's advantage to join forces for computer application. By so doing it would be possible for the single hospital to have access to hardware of a capability impossible to acquire by itself. In terms of programming expense, this would also be shared with many others. This would necessitate agreements as to participation, and to sharing capital and/or operating costs.

It does not make sense for all but perhaps a very few large and unique hospitals, mainly university connected, to install individual computers. Unfortunately there is very apt to be a large amount of money expended by individual hospitals for computer installations, probably largely wasted, that could much better be pooled for better results.

Thus the small hospital probably cannot by itself think of an individual computer, but it definitely can in cooperation with others. The potential of the computer is literally breathtaking, and will do much to bring all hospitals—from medical center to the smallest unit—together. Further, the eventual application will likely be extended from the hospital to the individual physician's office to provide an even greater degree of integration.

It is, however, not now premature for the small hospital, *in cooperation with others,* to take initial steps in the formation of "compacts" for computer development. It would be well to seek expert advice; in the Tri-State area the University of Michigan is an excellent resource with some experience already gained in the hospital field.

"Management" Engineering. I do not know of any research that has conclusively demonstrated smaller hospitals to be more inefficient or costly than larger institutions, except possibly those small hospitals located in large, urban areas. I do not believe this to be the real issue. But large or small, hospitals are under continuing and harassing attack in terms of productivity and costs. It stands to some reason that smaller hospitals do have greater problems in regard to these questions because of their comparatively limited resources in terms of plant investment and operating capital.

I believe that all hospitals must become more concerned with these questions. But perhaps small hospitals have a more difficult problem in coming to grips with them than do larger institutions. But there are ways and means for any hospital to adopt something other than a passive attitude. For example, "HAS" and "CAP" are ongoing national programs very much concerned with productivity and costs, and which came into being mainly for the benefit of smaller hospitals in this country. Their cost is reasonable; there is no excuse for any hospital not participating. In another area the same case stands for "PAS" and "MAP" related to patient care studies and practices.

In my ken we are also on the threshhold of some kind of similar breakthrough in regard to so-called "management engineering," or the application of industrial engineering to the hospital environment. Some regional councils have already taken steps to bring the benefits of industrial engineering to the individual institution. Results have varied, but in at least one area, Southern California through the CASH program, results have been substantial. CASH was not conceived as a crash effort, but represents a combined practical research, service, and educational venture. Its 140 plus member hospitals, most relatively small, contribute on a prorated basis, and receive value considerably greater in terms of cost reductions, greater efficiency, and yes, improved standards. Another very successful cooperative program is being conducted in Maryland.

Here is another example of the relative impossibility of an individual small hospital being able by itself to obtain the skills of industrial or management engineering. But cooperatively it is possible, as CASH is so well demonstrating. Again, improving productivity and stabilizing costs are two of the major problems in hospitals today. Management engineering is a technique that is available and does have validity in the hospital setting—including direct patient care. Where through a joint approach its benefits can be brought to the smallest hospital, the field is vulnerable to justified criticism if it does not act.

Education and Manpower. The small hospital, through the regional council or the health planning group, must take more postive steps to help itself in resolving manpower problems. And through the exploding community college movement, now at the rate of one new college weekly, there is considerable promise. The community college is very much interested in meeting the technical personnel needs of the area it serves. Although the college may consider its obligations primarily on a local community level, there is no reason why the scope cannot be expanded to a regional basis.

Councils should evaluate their manpower needs on a continuous basis; how many nurses, aides, X-ray and lab technicians, et al, are presently needed and will be in the future? Within an area of 10 counties perhaps only one program in some fields should be offered to meet the needs; in others perhaps two or three could be justified as based on likely demand. I believe those colleges within the region would be very willing to participate in such an approach.

The possibility of multiple area financing should be considered. In interstate regional education compacts, such as SREB, there is a sharing of the cost of certain very expensive professional programs. In terms of intrastate regions perhaps the same principle could be developed, with districts contributing. For example, a compact to finance an expensive A.D. nursing program might be spread among several educational districts, within a given hospital council region.

Television. There is currently a very limited number of experimental TV programs, mainly educational, linking several hospitals. Although the present cost is such to be almost prohibitive except as demonstrations underwritten by outside financing, at some point it will be feasible. In education, airborne television has been in use for several years. TV undoubtedly has great potential for hospitals as well.

In West-central Michigan a group of hospitals, spearheaded by smaller institutions, has been exploring TV linkage for some time. The medical staffs are keenly interested, as a means of communication with medical centers. Other benefits in addition to educational values have been documented by this group. A regional TV compact arrangement is being proposed, beginning with a limited number of participants.

Similar to computer networks, TV arrangements will be regional in nature at first, and then linked to other networks in a state, and possibly interstate as well. Although again education is a principal objective, other uses, e.g. direct patient service, will be possible.

Central Services. The field is very gradually moving to the sharing of certain services and facilities, even where the participants are widely separated geographically. A prosaic illustration is the laundry, where across the country a growing number of groups are now active. Many other kinds of arrangements to share facilities and equipment will be developed. It is believed that a central laboratory service using very costly equipment for many procedures is quite feasible, and will reduce costs substantially while improving and standardizing procedures. Such centralization also contributes to a pooling of skilled and scarce personnel.

Equipment is now available which is said to be capable of processing as many as 2200 blood tests daily, with one or two technicians. A skilled analyst using manual methods might complete a similar volume of work in several weeks. Here again the single small hospital could not justify such equipment, nor would it by itself have this much volume to even warrant consideration. But by combining many hospitals, volume of course is achieved, through which economies can be obtained.

Organization and Administration. Still another logical compact arrangement will be developed involving basic organization and administration of several hospitals. This relates to two or more hospitals, geographically separated, entering into an agreement to share an administrator, and from that point other personnel and services. There is really nothing new about this thought, and there are existent a few examples across the country. But the benefits are so obvious it is difficult to understand why there aren't more. One apparent difficulty has to do with that old shibboleth of hospitals—autonomy. But there is no reason why this should be a real barrier if the arrangement is appropriately and mutually developed.

Previously I said that the key to "survival" lay in compacts such as mentioned, but also stressed the importance of regional hospital council staffing. For unless the latter occurs, the kinds of programs described will be much more difficult to mount, and longer in activation. This means a willingness of hospitals to increase substantially their organizational dues to a point possibly greater than the combined national and state. The executive head of the organization must be as fully qualified as the state director.

It will be his responsibility to help in the shaping of new approaches to cooperative ventures.

Entirely aside from the joint programs involving multiple hospitals, there is one other significant and I believe highly desirable factor that will greatly influence small hospital development in the future. This is a step that will involve most hospitals in a new type of service, and one that will be of substantive benefit to the community. But aside from these aspects, it will have considerable economic implications.

This relates to the hospital's assuming direct responsibility for long-term care as an integral part of its operation. One of the critical problems of small hospitals is its limited economic base. Already discussed has been the multiple or compact approach, which in itself broadens each unit's capabilities. But the addition of long-term care beds is a practical way of not only meeting an acknowledged community and social need, but also strengthening the whole economic structure of the hospital enterprise. It will be possible to spread costs across 80 beds vis a vis 40 acute alone, and so on. Admittedly, this is on the premise that reimbursement under Titles 18 and 19 will be adequate; my assumption is that this will be so.

MY BELIEF IS THAT there will be a very rapid extension of the hospital into the long-term care field. The term "small hospital" will eventually only be a relative term, as likely the typical small hospital will be at least 100 beds. And another development I predict is that in many of these hospitals the acute section will be in the minority. This will call for quite an adjustment in our thinking as to what represents hospital care and services.

Perhaps these comments have covered too many aspects of the small hospital—its dilemmas and prospects. To be sure the small hospital does have some unique and frustrating problems. But the small hospital has never had a more promising and truly exciting future. The isolation and insularity of the past are rapidly disappearing. Through a combination of many forces and influences hospitals will be linked together in numerous ways. The acknowledged gap between the large, urban hospital and the small institution will be substantially erased.

Through computer and television networks (and I suspect other devices today unknown) hospitals will be brought together in a fashion that will truly "regionalize" medical care, from the local physician's office to community hospital to regional center to university teaching complex. Many services will be combined involving hospitals widely separated geographically. The community hospital itself will be numerically larger in the sense of total beds, as it embraces long-term care on an extensive basis. It is difficult to identify any opportunities in the field that will be more challenging, interesting, and provocative than those related to the small hospital. To borrow a phrase "This is where the action will be."

Lateral Abdominal Tenderness: Spigelian Hernia

ABSTRACT — The case of a 39-year-old male with a two-week history of vague right lower quadrant pain is presented. Surgical exploration revealed a hernial orifice that contained a Richter's hernia in a Spigelian location. A necrotic area of the anterior cecal wall was found. The necrotic area of cecum was resected and repaired with a two-layer closure. The hernial orifice and surgical incision were closed in a transverse fashion.

BY MARTIN BEARD, M.D.
FLINT
A. VELANDER, M.D.
MINNEAPOLIS

Lateral ventral hernias generally cause no difficulties in diagnosis and are seen with moderate frequency. The greater percentage of these are inguinal or femoral hernias. A more unusual hernia is the spontaneous lateral ventral hernia — Spigelian hernia — that appears to be reported with increased frequency in the recent literature.

During the past year, one case was seen at the Minneapolis Veterans Hospital. This case is reported below.

CASE REPORT

L. V. Y., MVAH:

A 39-year-old white male was admitted to the Surgical Service of the Minneapolis Veterans Administration Hospital on 9/19/66 because of right sided abdominal pain of two weeks duration. The abdominal pain had become worse on the a.m. of the date of admission. There was no history of jaundice, dark urine, clay colored stones or melena. There was no history of recent abdominal trauma.

The patient did admit to fatty food intolerance and frequent belching following the ingestion of cabbage. Several days prior to admission, the patient had helped in the roofing of a house.

Past history revealed that the patient underwent an appendectomy as a child, had a subtotal gastrectomy at age 23 for a gastric ulcer and had been examined for back pain. Normal cholecystogram was demonstrated one year prior to admission.

The initial laboratory data showed the following: Urinalysis - Normal; Sugar - 0, Albumin - 0; Hematology - WBC - 18,300, neutrophils - 89, lymphocytes - 11, Hbg - 14.0 gm.%; BUN - 8 mgm.%; Bilirubin - total 0.5 mgm.%, direct 0.1 mgm.%; Stool Guaiac - Neg; Serum amylase - 58 units; Prothrombin time - Normal.

Physical examination: B.P. 134/80, Temp. 99.4 (0), Pulse - 84/mm. Well developed and well nourished male.

Positive physical findings:

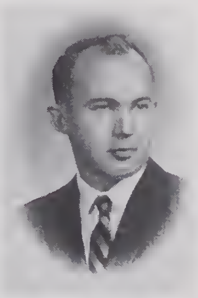
1. Healed left subtotal gastrectomy incision.
2. Healed McBurney's type incision of right lower quadrant.
3. Point tenderness and pain just lateral to right rectus muscle, but medial to old McBurney's incision.

The pain persisted after a period of six hours while the patient was put on nasogastric suction. There was no radiation of the pain and it was more severe with straining and standing.

The patient was taken to the operating room on 9/19/66 and through a transverse incision, the skin and subcutaneous tissues were incised. A small area of induration measuring 2 x 2 centimeters could be palpated adjacent to the right rectus muscle, but medial to the old McBurney incision. The indurated area reduced into the peritoneal cavity under relaxation due to the general anesthesia. A transverse defect was present in the lateral musculature with preperitoneal fat, transversalis fascia and peritoneum protruding through the separated muscle bundles. The peritoneal cavity was entered and a necrotic area of

THE AUTHORS

BEARD


VELANDER

Doctor Beard, formerly with the Department of Surgery, University of Minnesota and the Minneapolis Veterans Administration Hospital, is now in practice in Flint. Doctor Velander is a resident with the Department of Surgery, University of Minnesota and the Minneapolis Veterans Administration Hospital.

the anterior cecal wall was noted. The necrotic area of the cecum was removed and the defect closed in standard two layer fashion. Palpation of abdominal wall was negative. The small and large bowel were examined, the abdominal cavity was irrigated, and the abdominal wall was closed by approximating the peritoneum and transversalis fascia in one layer and closing the fascia, subcutaneous tissue and skin along the line of incision.

The patient developed a superficial wound infection postoperatively, but this healed without consequence.

DISCUSSION

Adrian Van Der Spiegel, (Figure 1) a disciple of Fabricus, was the first to describe the linea semilunaris. An early work of Spiegel's contains this description (Figure 2).

The first to recognize a hernia of the linea semilunaries was probably La Charesse, but this hernia was considered to be traumatic in origin.[5] Klinkosch presented the first vivid description and first located a spontaneous lateral ventral hernia of the linea semilunaris.

Anatomically, the linea semilunaris extends from the ninth costal cartilage, in a curved manner, on the anterior abdominal wall to the pubic spine. It marks the lateral boundary of the rectus abdominal muscle.

There appears to be some confusion as to what constitutes Spiegel's line. Watson states that the linea semilunaris is formed by the aponeurosis of the internal oblique at its point of division to enclose the rectus abdominis muscle.[4] River feels that the linea semilunaris is the transition between the muscle bundles of the internal oblique and the

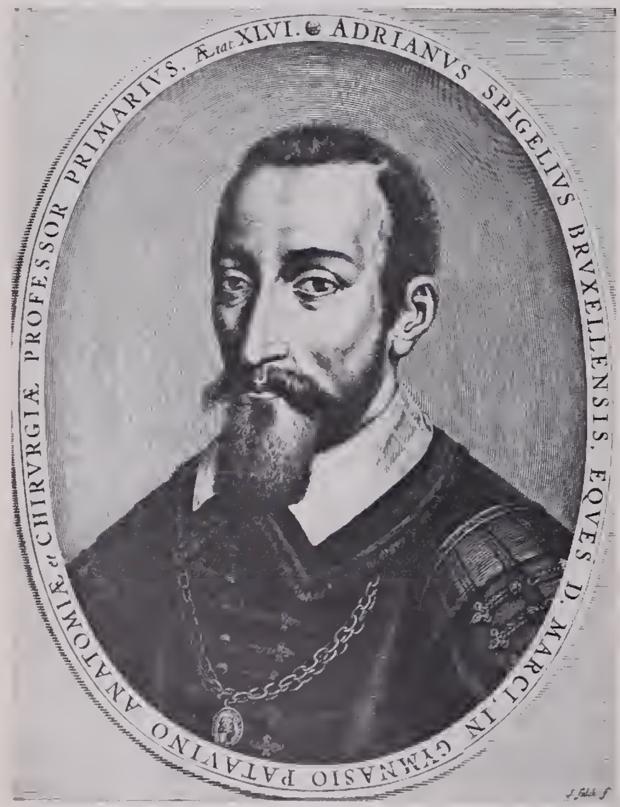

ÆTAT XLVI. ADRIANVS SPIGELIVS BRVXELLENSIS. EQVES D. MARCI. IN GYMNASIO PATAVINO ANATOMIÆ et CHIRVRGIÆ PROFESSOR PRIMARIVS.

FIGURE 1. Adrian Van Der Spiegel (1578-1625) was born in Brussels; he studied and taught at Padua between 1618 and 1624.

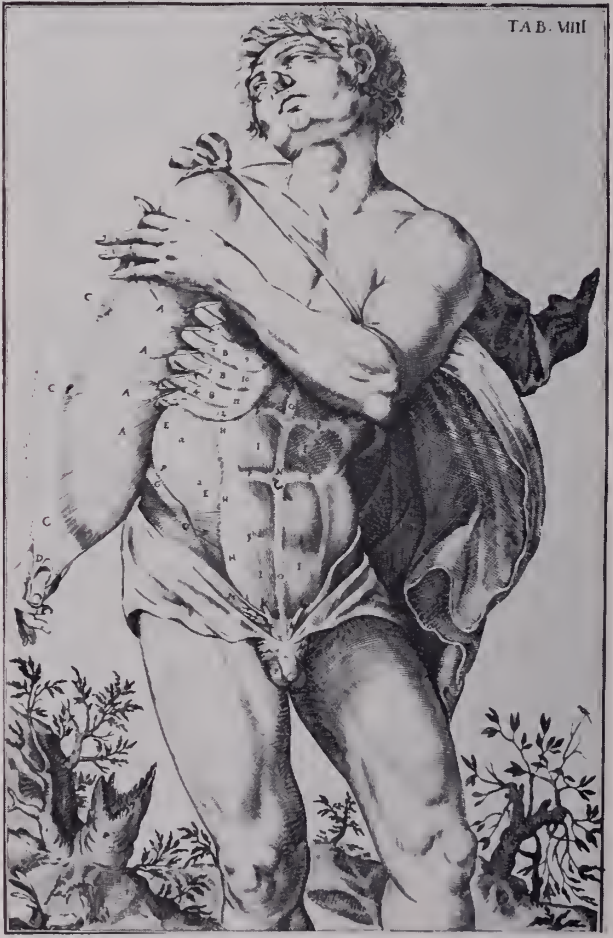


FIGURE 2: HHH-Semilunar line named by Spiegel. The tendons of the oblique muscles of the abdomen begin here.

TABLE I

Defects Found in Internal Oblique Aponeurosis (Taken from Zimmerman, Anson, Morgan, and McVay)

No. of Defects	No. of Cases with Defects	Percentage of Total No. of Cases (500)
1	74	14.8
2	32	6.4
3	3	0.6
Total	109	21.8

TABLE II

Defects of internal oblique and transverse abdominus aponeurosis alone or together and superimposed as found in 100 body halves. (Taken from Zimmerman, Anson, Morgan and McVay)

Defects	No. of Cases	Percent of Cases
a. One or both internal oblique and transversus not superimposed.	45	45
b. Internal oblique alone.	25	25
c. Transversus alone.	10	10
d. Internal oblique and transversus superimposed.	6	6
e. Transversus cranial to that in internal oblique.	4	4
Total	100	100

aponeurosis of the same muscle.[6] This places the line lateral to the border of the rectus muscle. In practice, Spiegel's line is a broad band[3] and is referred to by some writers as Spiegel's fascia.[5]

The most common site of Spiegel's hernia is below the umbilicus along the lower one third of the linea semilunaris. The muscle fibers of the transversus reach behind the rectus in the upper two thirds or three fourths of the line. This probably accounts for the rarity of herniations above the umbilicus.

Factors that favor spontaneous lateral ventral hernias are obesity, paralysis, multiple pregnancies, emaciation following obesity, chronic cough, straining or increased intra-abdominal pressure from any source. Cooper feels that protrusions occur through perforations that transmit vessels when these orifices are of unusual size or enlarged during a relaxed state.[8] Some writers report the importance of the weak spot that exists where the semilunar line crosses the fold of Douglas[4] (Figure 3). River has described slit-like defects in the aponeurosis of the transversus as it passes forward and fuses with the internal oblique.[6] Some authors ascribe great significance to the lateral branch of the inferior epigastric artery transversing one of these defects.[6] The orifices are described as being 0.5-0.2 cm. in size and seldom larger.

Zimmerman, Anson, Morgan and McVay have shown that the inferior medial extent of the internal oblique and transverse muscle sometimes consists of interdigitating muscle fibers separated by weak aponeurotic structures through which herniations occur. Their findings are shown in Tables I and II.[13]

As shown in Table II, defects in the transversus and internal oblique aponeurosis were superimposed in 6% of the body halves. This allows for potential herniation in this 6% of cases.

The explanation of Zimmerman et al appears to best explain the anatomical basis of the lateral spontaneous ventral hernia since blood vessels do not accompany the hernia orifices with any consistency and there does not appear to be any one site of weakness where the herniation occurs.

Spigelian hernias occur in both sexes with equal frequency and are more prevalent in the fifth and sixth decades.[5] Since January, 1958, 2541 inguinal hernias and only 6 Spigelian hernias have been

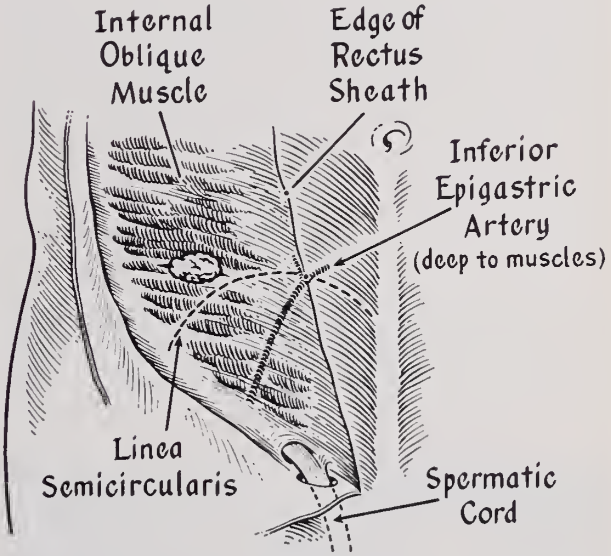


FIGURE 3: An artist's illustration of the course of the inferior epigastric artery deep to the abdominal muscles. The orifice through which the lateral branch of the inferior epigastric artery passes has received great emphasis as the site of the Spigelian hernia. The point where the semilunar line crosses the fold of Douglas has also been incriminated as the site of Spigelian hernias.

surgically corrected at the Minneapolis Veterans Administration Hospital.

Lower abdominal tenderness or pain aggravated by straining or standing and relieved by lying down is characteristic of a Spigelian hernia. The patient may complain of a lump that comes and goes and is located below the umbilicus and lateral to the rectus muscle; it may have a gurgling sound. A Spigelian hernia may stimulate appendicitis, cholecystitis, urinary bladder stones, salpingitis, appendiceal abscess and hematoma or tumor of the abdominal wall. When the ordinary abdominal exploration does not explain lower quadrant pain, the anterior abdominal wall should be carefully palpated from the peritoneal side for the defect of the Spigelian hernia as the hernia may well reduce under muscular relaxation or the slightest manipulation at the time of surgery. Herniations through the semilunaris are usually small and spread beneath the intact external aponeurosis, but large Spigelian hernias do occur.[9]

A symptomatic hernia should be surgically repaired. The neck of the sac should be ligated or sutured after it has been dissected free. As with any hernia, nonviable intestine or strangulated omentum should not be overlooked. The peritoneum and transversalis fascia are sutured and the overlying muscles and aponeurosis are closed with interrupted sutures. A Mayo type repair is sometimes used.[5] A transverse incision over the point of tenderness is very useful.

SUMMARY

A case report of Spigelian hernia with a Richter's component has been presented with a brief review of the literature. In cases of lower lateral abdominal pain and/or tenderness, the differential diagnosis includes Spigelian hernia. Identification of the hernial orifice with ligation or suture of the sac and repair of the overlying muscles and aponeurosis constitutes adequate surgical therapy.

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Team physicians, coaches, and trainers jammed the Rackham Building conference room to participate in the MSMS Conference.

Coaches, Trainers Team Physicians Get Many Pointers

One hundred coaches, trainers, principals and team physicians conferred in Detroit for the Third Annual Michigan Conference on Medical Aspects of High School Sports, sponsored by MSMS and the University Center for Adult Education (WSU-EMU-UM).

Robert J. Murphy, M.D., team physician at Ohio State University, makes a point on "Medical Aspects of Athletic Conditioning" to an audience of team physicians, coaches, and trainers at the MSMS Conference at the Rackham Building.

Team physicians and coaches from Ottawa County talk with James Feurig, M.D., lower left, chairman of the MSMS sponsoring committee and MSU team physician, during the annual Sports and Medicine Conference. Each year, the Ottawa County Medical Society sends a group to the conference as a public relations project.

Richard H. Smith, M.D., right, of Detroit, chats with an old friend, Leslie M. Bodnar, M.D., Notre Dame team physician, during the recent MSMS Conference. Doctor Bodner, who spoke on "Ankle and Knee Injuries," was an instructor in South Bend, when Doctor Smith was interning there.

Reviewing some of the comments made by Howard (Jeep) Mehaffey, D.D.S., right, a former U-M fullback and guard — now with the Michigan Department of Public Health — are William Taft, center, Lansing Waverly High coach, and H. Ross Hume, Jr., M.D., of Detroit, a member of the MSMS sponsoring committee and physician for the Detroit professional soccer team.

CITES STATISTICAL DIFFERENCES

Says Programs for Aging Need More Sophisticated Approach

The concept that people over 65 are essentially alike is one of America's "romantic fallacies." Vast differences exist in income, age, sex and education, according to Dean Walter M. Beattie, Jr., Syracuse University School of Social Work.

Dean Beattie, who spoke at a Wayne State University Symposium, "Extending the Life Span: The Impact on Man," noted that within each five year period more than a third of the older population is new to the age group. All of these newcomers have lived through a different period of history, a somewhat different culture, changed schooling, changed economic conditions than have older members.

These differences should be taken into account when planning services, housing, options and alternatives. Yet, most of our planning and service provisions have been based on the concept that somehow all people over 65 are alike, he said.

A statistical breakdown of group characteristics shows the need for a more sophisticated approach when developing programs for our older population, he intimated.

EACH YEAR SOME 1.4 million people reach 65 years while 1.1 million die. Thus, some 300,000 older persons are added annually to the older population. This group exhibits vast differentials of experience, resources, and background than those 73 years and older, born before 1894, who make up half of the older population. Of every 100 older persons today, six are 85 and older. This six percent represents about one million people born before 1883 and includes some 16,000 Centenarians born before or during the Civil War.

The older population exhibits a disproportion of sex ratios: currently 11 million women to about eight million men. In the younger aged groups, 65-74, there are 125 women for every 100 men. At the other end of the continuum, 85 and over, there are 160 women for every 100 men.

Dean Beattie related to the WSU symposium the differences in education to earnings, work and social status, communications, understanding, taste, pursuits and attitudes. Currently, nearly 17 percent, three million of the older population, have less than five years of elementary schooling. They are functionally illiterate. Five percent are college graduates. But a different group of older persons will emerge by the end of the century, he said, in terms of educational resources and ability to cope with changing situations.

CONTRARY TO POPULAR belief, only a small minority of the aged live in institutions. Ninety-six percent live in the community, about 70 percent in family settings and 26 percent alone or with relatives. Close to 30 percent of those 65 and over, who reside outside of institutions, are at or below the poverty level.

Their biggest source of income, almost one-third of total revenue to all over 65, is earnings. The combination of payments from regular retirement programs contribute about 40 percent; 30 percent is derived from Social Security and six percent from Railroad Retirement and Civil Service. Only three percent of income is attributed to private pension plans.

THE OLDER POPULATION spends almost all disposable income on a hand-to-mouth basis for consumption goods: food, shelter, clothing and medical care. They represent very large proportions of urban poor.

Dean Beattie told the Detroit audience that the median value of all assets of older people totals some $11,200. But if one takes away home ownership, the median assets total only $3,000. Personal debt amounts to about one percent of assets.

He suggests that sound social policies, which would vest the right to retirement benefits in the individual and allow people to "carry" retirement provisions from one area of employment to another, could substantially raise the economic level of future retirees.

"In consumer patterns, older persons live a very marginal life as compared to the rest of the population," he concluded.

(Statistical data for Beattie's comments were taken from: "A Profile of the Older American," by Herman B. Brotman, U.S. Department of Health, Education and Welfare, Oct. 16, 1967).

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DORSEY Season

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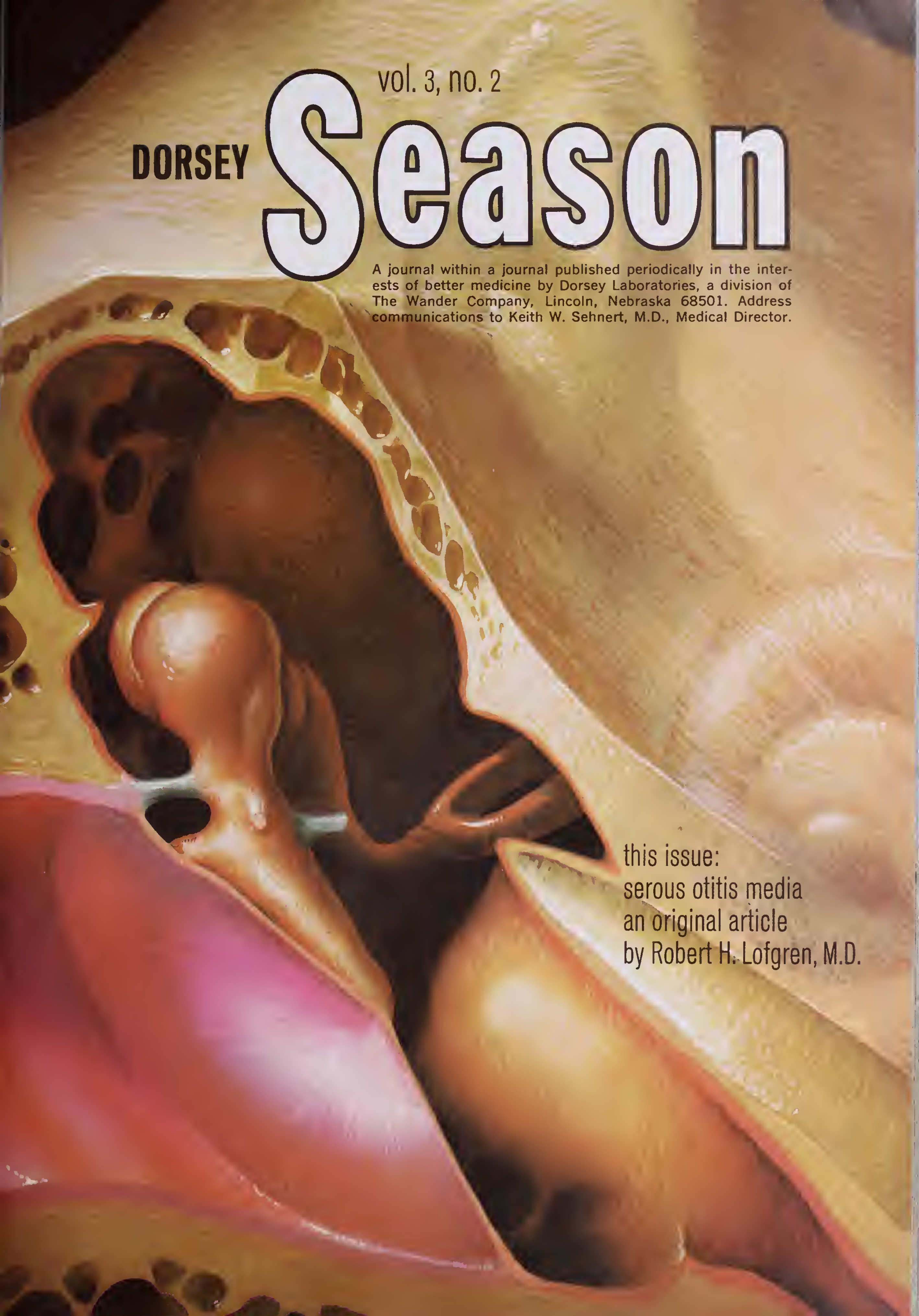
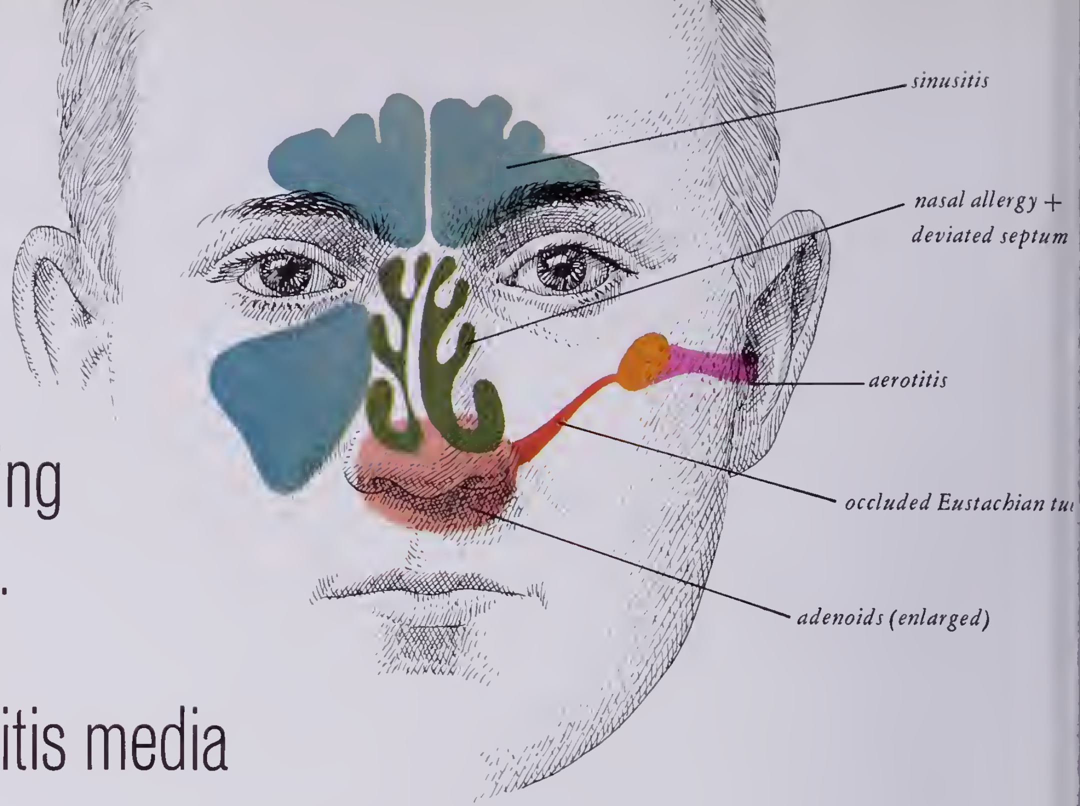


this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
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Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

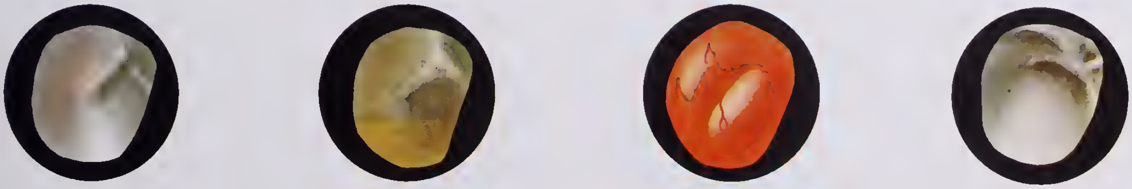
If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal　*Acute Serous*　*Acute Purulent*　*Chronic Serous* dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

Urge Every MSMS Member Attend September 25-26

Ask Residents, Interns, Seniors Confer Sept. 26

An educational "Conference on Office Management" will be offered for residents, interns and senior medical students on the afternoon of September 26 at the Sheraton-Cadillac Hotel in Detroit, during the MSMS Annual Session.

The MSMS Liaison Committee with Residents, Interns and Senior Medical Students has studied various topics for the conference. The Committee decided that the program should focus on basic principles of office management. Conference topics were narrowed to four: (a) opening an office, (b) selecting personnel, (c) billing system, and (d) evaluating partnership prospects.

"The Committee is grateful to Merck, Sharp and Dohme for financial support of this conference and feels that this unique event will not only be of educational benefit to the young or prospective physician but also will serve as an effective way of introducing him to the activities of the Michigan State Medical Society," reports Norman D. Henderson, M.D., East Lansing, chairman of the sponsoring MSMS Committee.

Four Day-Long Courses Set for Annual Session

The two-day annual MSMS Annual Scientific Session, Wednesday and Thursday, September 25-26, at the Sheraton-Cadillac Hotel in Detroit, will feature four, day-long postgraduate courses in "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases," and "Difficult Decision in Digestive Diseases."

The Wednesday, September 25, courses on "Infectious Diseases" and "Pulmonary Diseases" will run simultaneously from 9:00 AM to 5:00 PM. Each course will involve approximately six hours of in depth discussion and presentation.

"Blood Diseases" and "Difficult Decisions in Digestive Diseases" will be held on Thursday, September 26 also from 9:00 AM to 5:00 PM.

All courses are limited to 45 persons; cost is $10 per course.

Advance registration is essential because of limitation of space.

Michigan Medicine will print further course information as it becomes available.

MARK CALENDAR TODAY FOR ANNUAL SESSION

New Applicants Deadline Soon For MVF-2 Plan

A new and expanded program of Blue Cross and Blue Shield benefits is now available to eligible MSMS members . . . but July 10 is the deadline for new applicants.

The new program inaugurates a realistic and up-to-date program of hospital and physician care benefits for MSMS members and their families. In addition to the well-known basic Blue Cross and Blue Shield benefits, it introduces benefits for care in convalescent facilities — outpatient psychiatric care — expanded benefits for nervous and mental conditions — plus the new Michigan Variable Fee system for paying physicians' reasonable and customary charges (MVF-2).

Complete details, rates and an application were mailed recently to every member.

Coverage will begin August 1.

All physicians presently enrolled in the MSMS-group for Blue Cross and Blue Shield coverage have also received details about the new MVF-2 Plan and will automatically be transferred.

International Health Speech Available

MSMS members interested in obtaining a copy of the address by William S. McNary, Michigan Blue Cross president, advocating an international reciprocity program for health care protection may obtain a copy by writing to Michigan Blue Cross, 441 E. Jefferson Avenue, Detroit 48226. Mr. McNary, speaking at the recent International Conference on Voluntary Health Insurance in Sydney, Australia suggested a voluntary program to answer the health problems of the international traveler.

Duncan J. McColl, M.D., center, Port Huron, who died May 26 received recent honors at the Wayne State University Medical School Alumni Association banquet in Detroit, May 15. Doctor McColl, who was graduated from WSU in 1893, was in the banquet spotlight with James J. Aiuto, M.D., left, the new president of the WSU Medical School Alumni, and Mario A. Petrini, M.D., retiring president.

LOWINGER LEADER IN RIGHTS GROUP

Paul Lowinger, M.D., Associate Professor of Psychiatry at Wayne State University, was elected national vice chairman of the Medical Committee for Human Rights at the annual convention in Philadelphia.

RECEIVES ADA AWARD

The American Dermatological Association has awarded its first Carl Herzog Fellowship for training teachers and researchers in dermatology to John J. Voorhees, M.D., Ann Arbor, a second-year resident in the U-M Hospital department of dermatology. The award includes a stipend of $10,000, and also $2,500 for equipment and travel.

D. J. McColl, 99, Dies; Was Honored By MSMS, WSU

Michigan's Foremost Family Physician for 1954, Duncan J. McColl, M.D., died May 26 in Port Huron Hospital at the age of 99.

"Doctor McColl has always devoted his energy and attention first to his patients and lastly to himself," said Charles N. Hoyt, M.D., acting secretary of the St. Clair County Medical Society, when Doctor McColl was named by MSMS as the Foremost Family Physician.

Illustrating this quality of Port Huron's late beloved physician, Doctor Hoyt cited an instance in 1952 when Doctor McColl, himself in the hospital with hemoglobin of 6.5 grams, could not be found by his physician: "In about an hour he returned to his room — he had been in the delivery room attending one of his patients."

On May 15 this year, Doctor McColl had attended the Wayne State University School of Medicine Alumni Association banquet, and had been presented with a Centennial Award.

Born on Nov. 24, 1868, on a farm in Elgin County, Ontario, Doctor McColl in 1889 entered the Detroit College of Medicine, which evolved into the Wayne State University School of Medicine.

He was graduated in 1893 and had been WSU's oldest living alumnus.

In 1896, Doctor McColl married Miss Helen Marr Clark, of Harbor Beach, and they settled in Elkton. Doctor McColl practiced there for 13 years, becoming the first president of the village. Then came six years in Croswell, and two years at St. Joseph Hospital in Milwaukee. In 1914 he moved to Port Huron where he practiced the rest of his life. He delivered more than 8,000 babies in Port Huron.

Survivors include a son, Clarke M. McColl, M.D., Detroit.

THREE U-M DEANSHIP CHANGES ANNOUNCED

John A. Gronvall, M.D., of the University of Mississippi Medical School, has been appointed Associate Dean for the U-M Medical School to succeed Alexander Barry, Ph.D., who will join the University of California School of Human Medicine at Davis. Dr. Gronvall, a pathologist, is associate dean and associate director of the University of Mississippi Medical Center.

Robert A. Green, M.D., who has served as assistant dean part time the past year, was appointed to the new position of Associate Dean for Student Affairs. The new office of Associate Dean for Academic Affairs will be filled by George R. DeMuth, M.D., member of the U-M pediatrics staff since 1956.

AREA REHAB WORKSHOP JUNE 27 AT SAGINAW

A Conference on Rehabilitation and Long Term Care will be held Thursday, June 27 through the joint efforts of the Bay-Arenac-Iosco, Saginaw, and Midland County Medical Societies. The MSMS Committee on Aging and the Saginaw Veterans Hospital also are cooperating in the seven-hour program at Saginaw County Hospital Rehabilitation Center.

MAP TV PROGRAM SWEEPS AWAY BLUES

Several Michigan physicians, Charles W. Sellers, M.D., associate editor of the *Detroit Medical News,* Bruce L. Danto, M.D., Director of Community Psychiatry at the Detroit Psychiatric Institute, and C. Howard Ross, M.D., an Ann Arbor writer, editor, and lecturer, joined host Hugh Brenneman, MSMS Executive Director, in a discussion of "Formula for the Blues" over WJIM-TV, Lansing, in the weekly series sponsored by the Michigan Association of the Professions.

MSMS, State Bar Studies Fee for Expert Medical Witness

What happens to the physician's fee, when on request of an attorney, he makes preparations to give testimony in court and then finds that the case is settled before the actual court appearance?

In 1957, MSMS and the Michigan Bar Association agreed on a statement of principle which read . . . "It is the responsibility of the attorney to advise his client of the physician's assistance and services in the case, and thus to cooperate with the physician for the purpose of seeing that such physician receives a reasonable fee for such services."

A joint meeting of the MSMS Liaison Committee with the State Bar of Michigan and the State Bar Medico-Legal Committee this spring recommended a rewording on this statement of principle as follows: "In cases where the physician aided in preparing the case but did not have the opportunity to testify or failed to testify because of a settlement prior to his being called as witness, it is the responsibility of the attorney to pay to the physician a reasonable fee for services rendered."

MSMS Council, at its April 17 meeting, approved this recommendation for rewording of the statement of principle.

The State Bar is currently studying the recommendation.

SLAGLE, SMITH ON NAT'L COUNCIL

George W. Slagle, M.D., of Battle Creek, chairman of the American Medical Association's Council on Medical Service, and Donald Smith, M.D., public health professor at the University of Michigan, have been named to a 21-member Advisory Council of the National Center for Health Services Research and Development, a new agency of the federal government.

The new center will work with universities, industry, hospitals, practitioners, and research institutions to seek new ways of delivering health care.

Doctors Slagle, a MSMS past president, and Smith will work with the advisory council which will be consulted on program development and practical operational problems involved in Medicaid (Title IX of Social Security).

GENESEE COUNTY PLANS 1969 DIABETES DAY

The Genesee County Medical Society has set the date for its fourth Diabetes Day, October 29, 1969.

Chairman for the Flint meeting next year is Franklin W. Baske, M.D.

John W. Moses, M.D., right, Detroit, arrives June 5 at the MSMS headquarters for his first meeting of the MSMS Publication Committee and the MSMS Council following his election by The Council in May as the new Scientific Editor of MICHIGAN MEDICINE. The official greeter is Brooker L. Masters, M.D., left, Fremont, member of The Council and chairman of the Publication Committee.

D. Bonta Hiscoe, M.D., of Lansing, talks with George Hunt, right, Managing Editor of LIFE Magazine, who gave the annual Yates lecture at Michigan State University recently, and Andrew Hunt, M.D., dean of the College of Human Medicine at MSU, brother of the LIFE Magazine editor.

Explains Dilemma In Medical Writing

"Whenever a story is chosen, there is a dilemma," said George P. Hunt, Managing Editor of *Life* magazine: "Is the story worth doing? Is now the time to do it? In the field of medicine, this dilemma is intensified."

Delivering the annual Yates lecture at Michigan State University, recently, Mr. Hunt observed that "In other stories there are clear rules and definite places where stories are found. But in medicine a major advance can just as easily come out of a small college or from Cal Tech."

"Even the experts," he continued, "don't all agree sometimes on whether something is really the first, the most, or a breakthrough."

"Another aspect of the dilemma," the *Life* editor said, "is that we have to be careful in reporting new advances in medicine. Will the story scare people? Will it raise false hopes?"

Mr. Hunt is the brother of Andrew Hunt, M.D., dean of the College of Human Medicine at MSU. The Yates lecture is an annual event sponsored by MSMS and other organizations which are interested in the advancement of science writing.

AMA Lauds MSMS Projects

Three projects of MSMS are described in the current issue of the *AMA PR Doctor* magazine published for county and state society doctors and staff members interested in better public relations.

One article suggested ways to improve town-gown relations and praised the "handsomely-designed" MSMS *Michigan Medicine* issue in 1967 which saluted the U-M Sesquicentennial.

Another voiced concern for better smoking-health educational programs and described MSMS support of the Michigan Council on Smoking and Health.

The third article reviewed the 1967 MSMS Workshop on Medical News Reporting sponsored at the U-M for science reporters, editors, program directors of TV and radio stations, as well as doctors serving on PR committees and bulletin editors.

Mutual Dependency

(The following editorial appeared recently in the Port Huron Times Herald:)

The Michigan State Medical Society is considering new approaches in education and enforcement to buck the spread of health quackery.

It's a big order, and an urgent one.

Dr. J. J. Lightbody, Medical Society president elect, says that phoney cures cost Americans some $3 billion a year. More than that, he says, they take more lives annually than all crimes of violence combined.

"Fraud, theft, death are strong, ugly words, but no single three words so well sum up the price society pays for lack of an effective program," he said.

The *Medical World News* in its March 29 issue examines facts and figures in one phase of quackery, treatments that are supposed to "cure" arthritis. Medical science admits that it has no cure at the present time, but 13 million victims of this ailment are receptive to almost anything that will give them a hope of relief, even a fantastic one.

It is estimated that at least 90 per cent of arthritis patients at one time or another fall prey to the empty promise — and frequently dangerous treatment — of an unqualified practitioner.

* * *

The problem is compounded because many of the quacks operate under a facade of respectability. Victims of their trickery are reluctant to bring action against them because they don't want to admit they have been cheated. Investigators term documented cases "the top of an iceberg," with no one knowing how much goes on under cover of anonymity.

The medical profession takes on a difficult assignment in seeking answers to this problem. It must do so in a way that will not discredit legitimate practitioners of the healing arts.

And it must do so in the clear understanding that it has a vested interest in closing down phoney health mills. The patients the investigators save may be their own.

Yet the hard fact is that there is no other source of expertise by which to judge the legitimacy of medical treatment than those who are of the medical profession.

The people must depend on them for honest judgment in this regard just as their patients depend on them for honest and competent judgment about physical disorders.

We can only urge the medical society to press forthrightly for means to control the quacks, wherever they are to be found, under whatever guise they are operating. And we urge every concerned citizen, and every organization, to co-operate in the effort.

The shattered hopes of hapless victims, along with uncounted wasted dollars and untimely deaths, are realities that must not be ignored. ☐

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WE WANT YOU TO BE SURE TO GET
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A simplified approach to the practical management of hypertension

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

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ENDURON®
METHYCLO-THIAZIDE
5 mg

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

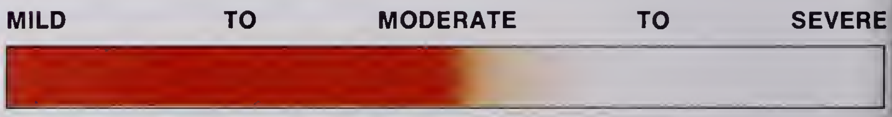
Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

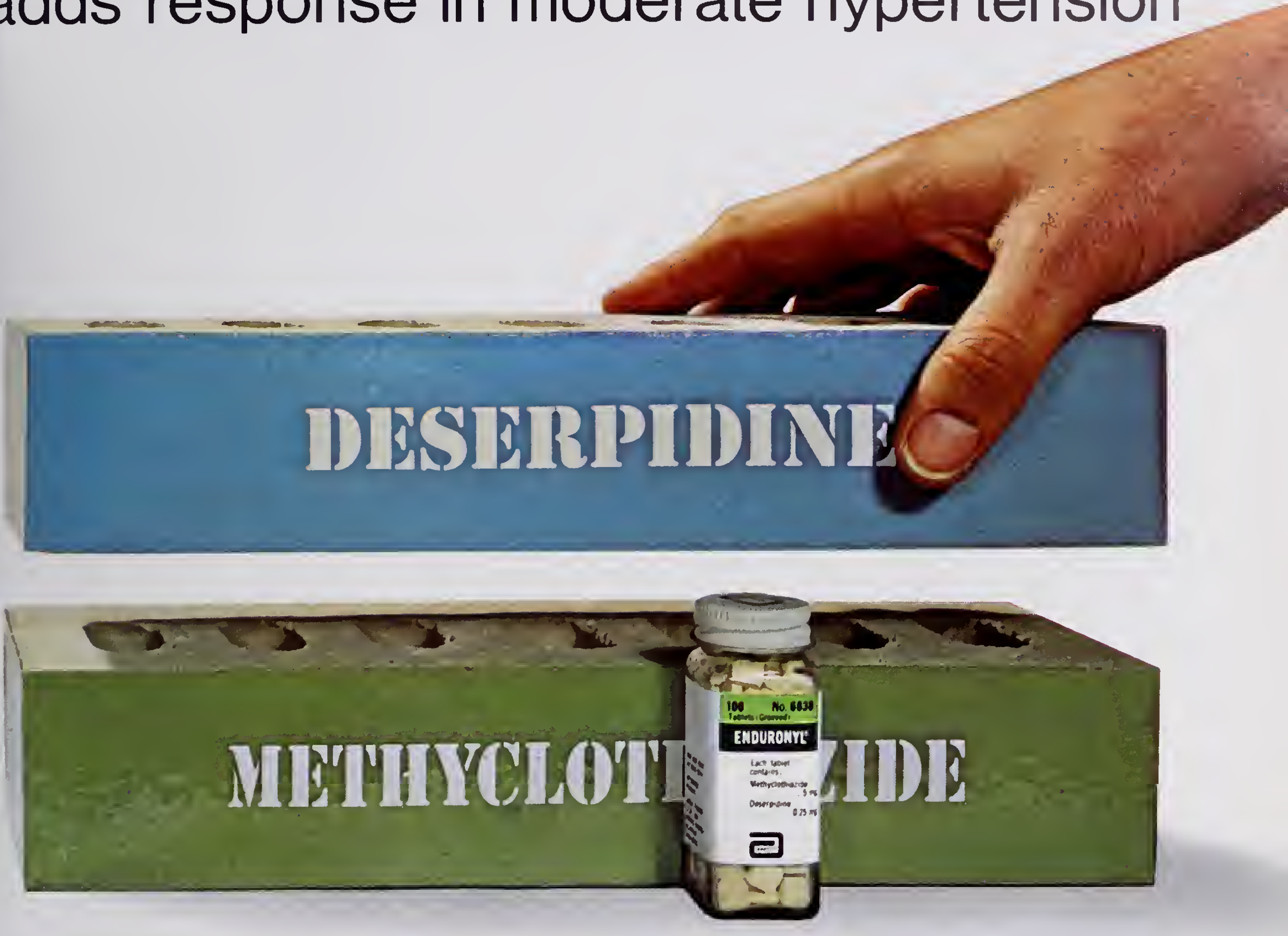
ENDURON

METHYCLOTHIAZIDE


MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension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METHYCLOT ZIDE
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ENDURONYL
Each tablet contains:
Methyclothiazide 5 mg
Deserpidine 0.25 mg

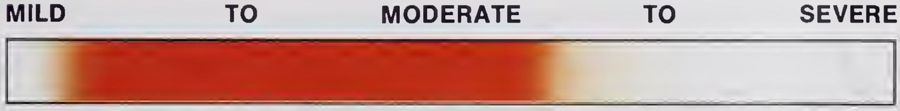
Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.



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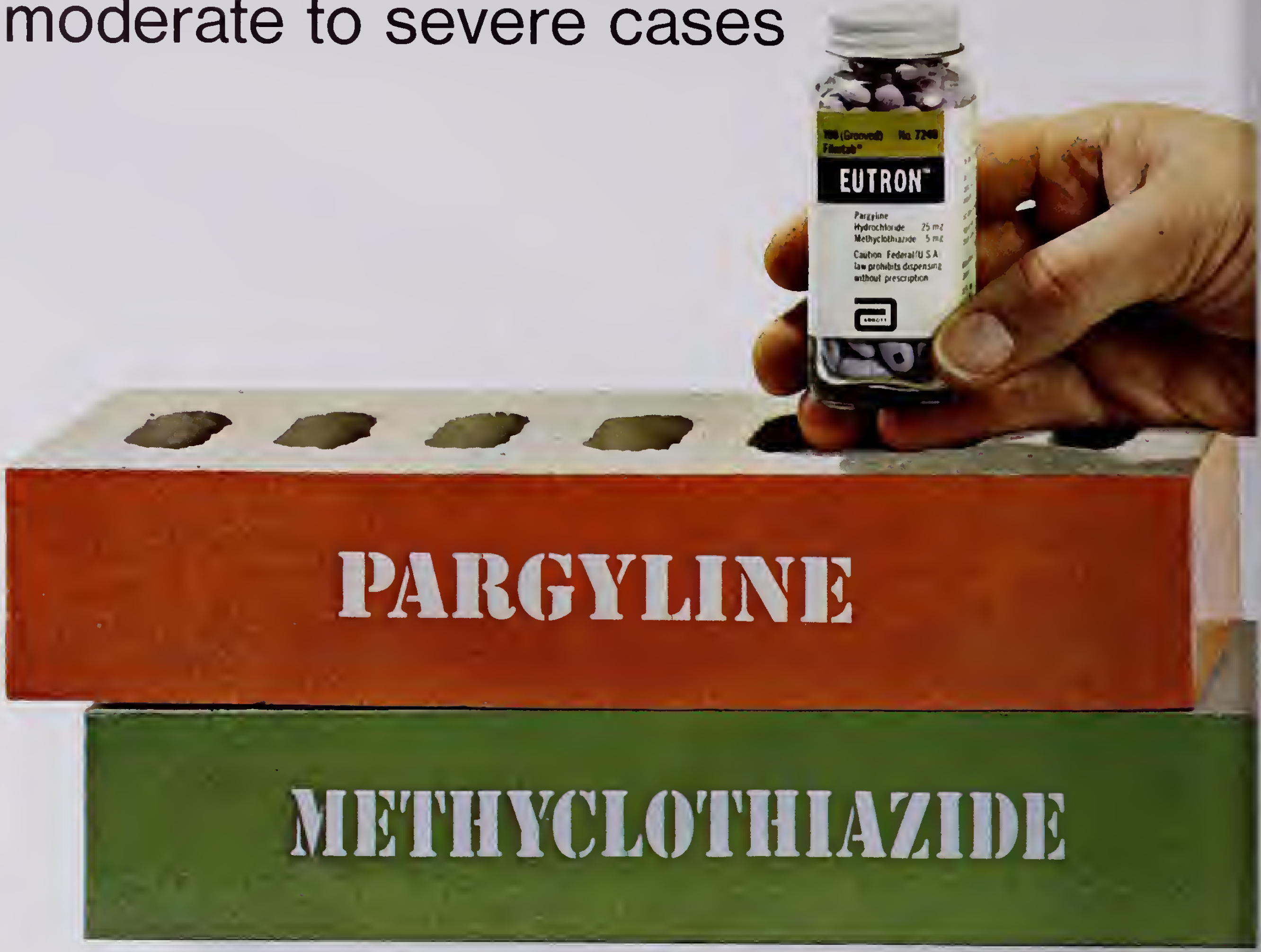
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal/U.S.A. law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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COMING EVENTS

COLLER-PENBERTHY-THIRLBY EVENT SET AT TRAVERSE JULY 25-26

All Michigan physicians are invited to participate in the 48th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 25-26.

The excellent program will begin at 9:00 a.m., July 25 and conclude at noon, July 26, according to James W. Hall, M.D., local chairman of the committee on arrangements. He reports that the out-of-state medical educators will come from California, Ohio, Florida, Missouri, Maryland, Nebraska, Minnesota, Texas, and Illinois.

MICHIGAN MEDISCENE

July 18-20 — MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island

July 20-21 — MSMAS Summer Seminar, Boyne Highlands, Harbor Springs

July 25-26 — 48th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place, Traverse City

Aug. 21 — The Council, MSMS Headquarters, East Lansing

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

Two modalities

ultrasound
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or combination of two
in one console unit

Now Burdick has combined ultrasound and electrical stimulation in a single, attractive console unit, the UT-4300.

Many have found that better results are obtained when ultrasound is combined with electrical stimulation — also used to advantage in **locating trigger-point areas.** Designed for convenience of the operator with controls arranged for easy access, the ultrasound and electrical stimulation modalities may be used individually or in combination. For detailed information call your Burdick dealer, or write us.

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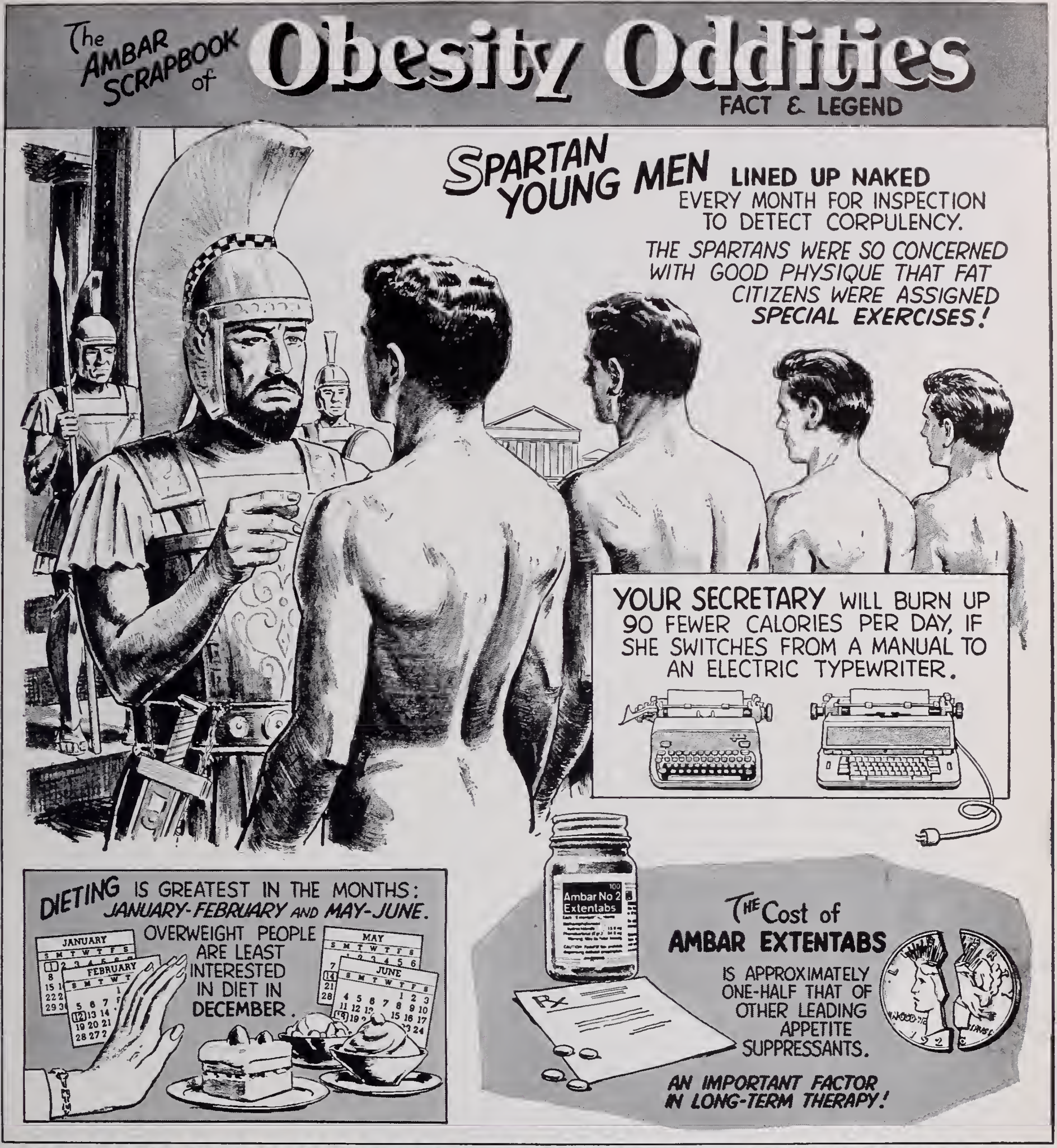
The AMBAR SCRAPBOOK of
Obesity Oddities
FACT & LEGEND
SPARTAN YOUNG MEN LINED UP NAKED EVERY MONTH FOR INSPECTION TO DETECT CORPULENCY.
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AN IMPORTANT FACTOR IN LONG-TERM THERAPY!

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AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
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(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

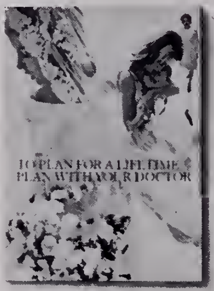
Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

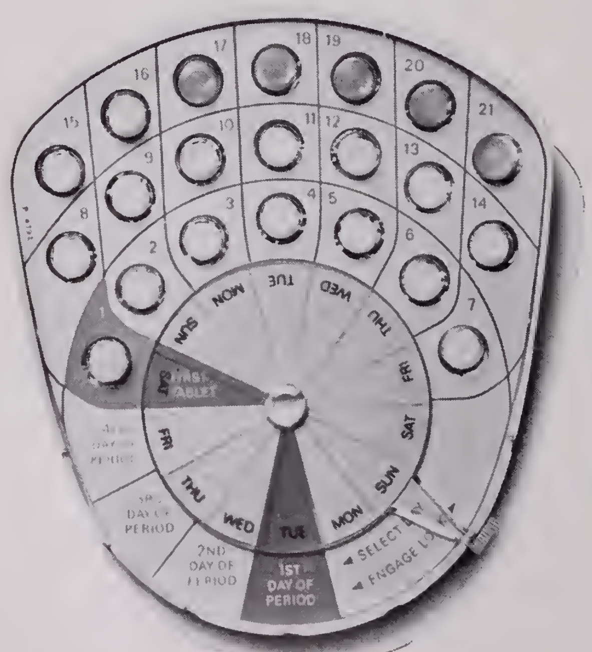
Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

to guide her in understanding and using conception control

A discussion of conception control for brides, "To Plan for a Lifetime, Plan with Your Doctor," is one of several booklets available through your Mead Johnson representative or directly from Mead Johnson Laboratories.

The Pakette® dispenser helps prevent patient error by showing her when to start her tablets and when to take every tablet all month long.





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Advice Offered at WSU Clinic Day To Help Doctor as Marriage Counselor

BY PETER HOHEISEL
OF THE MSMS STAFF

What can the physician do, and how does he measure up, as a sex and marriage counselor?

What are the special problems in a physician's marriage?

Those were the central questions which the annual Wayne State University School of Medicine alumni program examined recently.

A total of 560 persons, the largest crowd ever, gathered in Detroit May 15 to hear five papers and a panel discussion devoted to "Human Sexuality and Modern Marriage."

SEVERAL SPEAKERS STRESSED that one of the reasons physician's have difficulty with their own sexuality, and in being effective counsellors to their patients, is that sex education in medical school is generally confined to reproductive physiology and sexual anatomy with the result that physicians are not significantly better equipped in terms of sexual attitudes and information than is any comparably educated person.

"Many recent surveys show," Peter A. Martin, M.D., Detroit, said, "that doctors are having trouble with sexual problems—their patients as well as their own. Physicians are improperly trained in medical schools to handle such problems and have trouble getting themselves and their patients to discuss sexual difficulties. It is unlikely that the doctor would be able to go further towards solving his patient's sexual problems than he is able to go with his own."

New president of the WSU Medical Alumni Association James J. Aiuto, M.D., backs this view: "There hasn't been sufficient training at the medical school level. At present only the University of Pennsylvania and Bowman Gray School of Medicine have integrated sex and marriage counselling into their curriculum. These schools also have good postgraduate programs for physicians in this field. Lafayette Clinic, however, is taking some steps in this direction by offering to interested physicians lecture series on this topic."

OUTLINING HOW THE physician can increase his effectiveness as a marriage counsellor was Richard H. Klemer, Ph.D., clinical professor of psychiatry at Bowman Gray School of Medicine.

MARTIN

KLEMER

He cited seven steps which the physician can take to help his patient resolve a marital difficulty:

1. Creating the climate in which the patient can talk about his problems.

2. Providing for the ventilation of emotional catharsis.

3. Providing the reassurance of acceptance of the patient's attitude and perhaps an additional reassurance as well.

4. Diagnosing the real problem with the patient.

5. Encouraging the patient's education and evaluation.

6. Helping the patient to examine all the possible alternatives, and to decide upon a specific action.

7. Motivating the patient toward completing the chosen action.

DOCTOR KLEMER WENT on to discuss three of these steps: Creating the climate, acceptance and reassurance, and motivation.

According to Doctor Klemer, three basic ingredients to creating the climate are:

1. The security given by the confidential attitudes and the physical surroundings in which the counseling takes place.

2. The interest and concern exhibited by the counselor.

3. The non-judgmental attitude of acceptance with which the patient's statements are received by the counselor.

"The non-judgmental attitude of acceptance is especially important," Doctor Klemer said. "This can be achieved only when the counselor has self-understanding of his biases and an ability to tolerate ideas and behavior which conflict with those biases."

"This kind of self-knowledge involves a lot of rigorous self-analysis and often some evaluative help from another professional person," he continued. "Only the physician who is honest with himself can hope to project the necessary attitude of non-emotional objective interest which will ultimately help the patient."

"Another major function of the physician counselor," Doctor Klemer said, "is to provide supportive acceptance and reassurance to the patient. In practical marriage counseling, as in psychotherapy, at least some of the necessary reassurance comes from the quiet acceptance of the patient's attitudes and verbalizations by the counselor. That the counselor is willing to hear such hostile and guilt-ridden thoughts and not pass judgment is often enough for the patient."

"THE FINAL MAJOR FUNCTION of the physician-counselor is to motivate his patient," Doctor Klemer concluded, "to follow through with whatever course of action has been decided upon by the patient after an examination of all the alternatives. This is the point at which the use of some actual direction and persuasion by the counselor not only seems to me to be justified but is also probably inevitable. Very often it is the physician's willingness to reinforce the patient's decision which provides the impetus for the patient to carry his plans through to a successful conclusion."

"Naturally this requires a considerable self-confidence on the part of the counselor himself. An important part of the counselor's ability to help his patient comes from the strength of his conviction of his own ability to help and his willingness to transmit that hopeful belief to that patient. In the end, it is the counselor's personality, his warm self-confidence, which will provide the acceptance, the reassurance, the cooperation and the motivation to help his patient solve his marriage problem."

WHILE IT IS TRUE that, as Harold Lief, M.D., director of the Division of Family Study at the University of Pennsylvania School of Medicine, pointed out, "not necessarily every physician, just as not every teacher, can do a good job in sex education," nevertheless the physician, because of the trust and confidence which the patient places in him, is in a unique position to counsel his patient with sex and marital problems.

THAT THERE ARE special problems in a physician's marriage was attested to in comments by Doctor Martin, clinical professor of psychiatry at both U of M and WSU schools of medicine, when he noted that "Doctor's wives constitute an unusually high percentage of the total number of professional men's wives admitted to the Institute of Living in Hartford, Connecticut."

"There is one marriage pattern which I have seen repeatedly in doctor's marriages," continued Doctor Martin. "The husband is a good, kind, hard-working humanitarian devoted to his mistress-medicine. Everyone thinks how lucky his wife is to be married to such a paragon of virtue. This unassailable position drives his wife to distraction. She over-reacts. She can't attack her husband's good deeds. If only he had a mistress instead of medicine, he could be the bad one and she could be the good one."

"In this pattern, the husband's game is, 'Look how good I am. I am so good and patient to accept such a horribly unappreciative, sick wife. She is bad and unlovable.' The wife's problem is that she doesn't know how to beat this game. She refuses to see him as he is because she is afraid to lose him. She fantasies that he is great and wonderful. She expects him to love her. If he doesn't, she feels she is guilty and unlovable. Her mistake is that she wants him to love her no matter how badly she reacts, no matter how sick she gets. He is so in love with being a long suffering, unappreciated hero he can't afford to break this picture by building her self esteem, recognizing her good points, her contributions, her desire for love and her attractiveness as a sexual object."

After discussing the changing attitudes toward sex in our society, especially the increasing demand for sexual fulfillment on the part of women, Doctor Martin observed that the life of a doctor today "has resulted in difficulty in sharing in the life of his family." He listed several stress points. They were:

One, the doctor is an authority. Perhaps, in part he chose his profession because he likes a position of authority and all sorts of attitudes both rational and irrational are developed towards him.

Two, the doctor is a public figure, is in the limelight, which his family shares in a somewhat different way: while he is subject to adulation as well as criticism, his wife may get a little reflected glory, but is more likely to have her weaknesses or mistakes greatly magnified.

Three, the doctor frequently has a legitimate excuse for being away from home much of the time and for being undependable for social engagements and family occasions.

Four, the doctor has an opportunity for contacts with nurses, patients, secretaries and his wife may well exaggerate his opportunities and explanation of them, because of anxieties relating to her own self-assurance and sense of desirability as a woman.

Goins Reports on Detroit Mother-Child Care Program

About 3500 indigent Detroit mothers have an opportunity for free prenatal, delivery, and post delivery care for themselves and care of their infants up to one year of age through the Detroit Maternity and Infant Care Project.

Currently the DMIC is running clinics in 5 Detroit hospitals which, except one, are near high indigent population areas — Crittenton General, Detroit Memorial, Hutzel, Mount Carmel, and Children's Hospital.

William Goins, M.D., project director, says, "We want to see what can be done to deliver not just maternity but comprehensive care to people whose needs are the greatest."

Not only is the DMIC woman assisted in delivering her baby, but she will also be given instruction on how, when, and what to feed it, as well as how to plan her budget so that she can feed it.

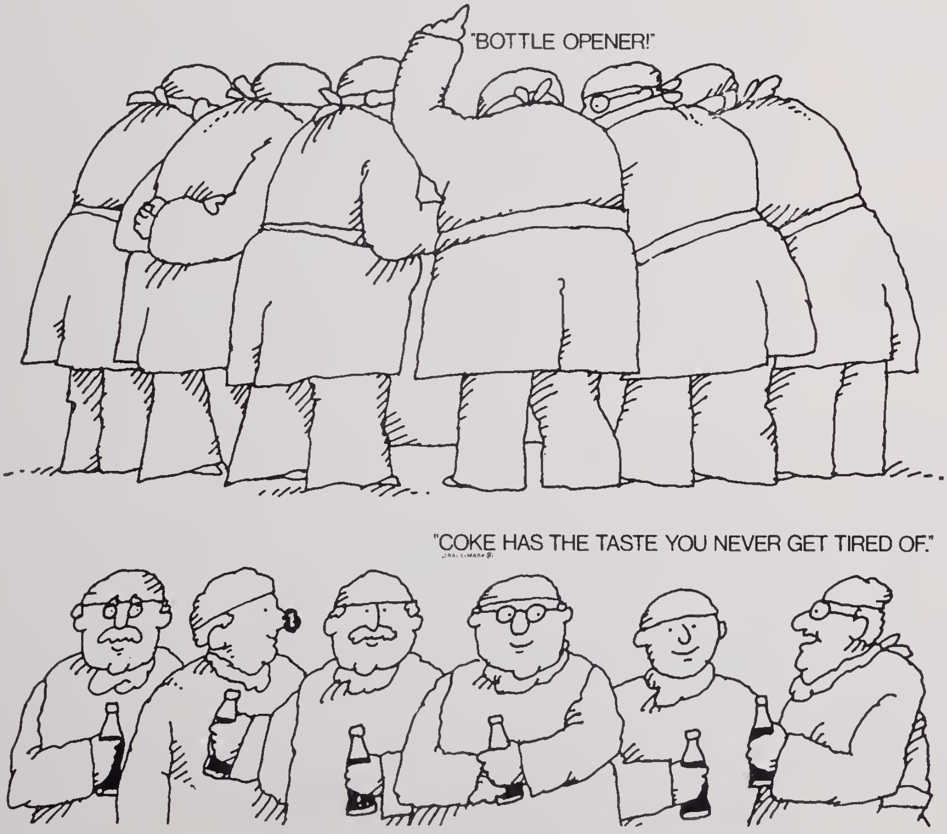
Aim of the project is to treat the indigent mother as a person: To help her use the potentials of her environment in a way which will be healthful to herself and her children.

The DMIC requires no means test for eligibility. "We accept the word of the mother," says Doctor Goins. "Very few people have abused this because if people have the money they generally prefer to go to their own private practice physician.

"Although we have not really made an impact on the high perinatal mortality rate among the poor," Doctor Goins said, "We do feel we are accomplishing our purpose because 90% of the women we help through delivery bring their children back for post delivery care. When the women know they are going to be treated with respect, given adequate time and attention and highly competent medical care, they respond by coming back. The clean wholesome atmosphere where people are kind to them brings the mothers flocking in."

"Compared to city wide statistics among indigent women, we have a very low maternal death rate," Doctor Goins said. "We're getting them in earlier, more often, and we're not losing mothers."

Started in 1964, the DMIC is one of 53 similar projects around the country. Personnel who work at the clinics in the hospitals participating in the project are paid through the project funds. It is funded at about $1 million a year by the Children's Bureau of HEW on a matching basis with the Detroit Health Department. □



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Where Does MSMS Stand re Legislation, Forensic Medicine, Laws, Regulations?

Where does MSMS stand on matters of governmental medicine?

That provocative question is one of 13 different subjects covered in a new MSMS workbook "Where Does MSMS Stand?" being studied by members of the MSMS House of Delegates and The Council.

Each of the 13 chapters is discussed, answering the question, in a discussion section, "What is the current thrust of MSMS and how are we doing?" This is followed by a series of questions which need some answers.

The workbook will serve as guidelines for the new Michigan Health Information Research Institute being developed by MSMS.

The November issue of *Michigan Medicine,* on pages 1139 to 1443, gave MSMS members the first information (1) about a new Michigan Health Information Research Institute and (2) about the many ramifications of the "Where We Stand" publication. The publication was developed by MSMS Executive Director Hugh W. Brenneman, who also is responsible for the MSMS Research and Development area.

Various chapters of the book are being printed each month for all MSMS members to study. This month, Chapter Ten is printed in full.

Discussion

Medicare
Medicaid

Governmental medicine has descended upon the physician and has become the focal point of concern. Since the beginning of Medicare in July 1966 and the partial implementation of the State Medical Assistance Program (Medicaid) in the fall of 1966, many problems of major and minor importance have developed for the practicing physician.

Medicare Administrative Burden

Initially, the physicians in Michigan discovered that there was a lack of understanding by the patient about the new laws. Doctors became well versed with the provisions of Medicare and made special purchases of hand books in order to understand and explain the many provisions. While it does now appear that the number of complaints is diminishing, Medicare is still an administrative burden for physicians, hospitals, and clinics in a number of areas.

MSMS Participation in Deliberations on Medicare-Medicaid

MSMS has taken a most active role in meeting many of these problems. Michigan doctors have participated in deliberations of governmental agencies (local, state, and national), voluntary medical insurance companies, hospital organizations, public health and social welfare agencies, and in the State Legislature. This, however, is not to say that problems with Medicare-Medicaid have dissipated. A continuous awareness and concern at all levels is necessary.

Generic Drugs

Food and Drug Administration

In other areas the governmental interest in medical practice has placed present methods in question—e.g., the physician's right to prescribe medicines and drugs in accordance with his best judgment. Some federal legislation and some regulations proposed by the FDA seem on a collision course with the practicing physician by proposing to insist that physicians prescribe by generic name rather than brand names as they have been doing of late.

Comprehensive Health Planning
Heart-Cancer-Stroke

Other governmental programs (PL 89-749, the Comprehensive Health Planning and Public Health Services Amendments of 1966, and PL 89-239, Heart Disease, Cancer, and Stroke Amendments) are receiving much attention and active participation.

Partnership for Health

Briefly, PL 89-749 authorizes funds to states to provide for developing comprehensive statewide, regional, metropolitan and other local area plans for the *coordination of existing and planned health services, including the facilities and persons required for the provision of such services.* HR 6418 is now before the Congress as Partnership for Health Amendments of 1967. It would amend the Public Health Service Act and extend the authorizations for grants in order to broaden and improve authorizations for research and demonstrations relating to the delivery of health services; improve the performance of clinical laboratories; authorize cooperative activities between the Public Health Service hospitals and community facilities.

Health Czar

In actuality, this legislation could be used to set up a potential health czar in Michigan. MSMS has felt that the "czar," if any, should be the Governor himself, particularly if the plans developed included *all* health services, i. e., mental, medical education, aging, etc., etc.

Heart Disease-Cancer-Stroke Amendments

PL 89-239, the Heart Disease, Cancer, and Stroke Amendments of 1967, is designed to encourage and assist in the establishment of regional cooperative arrangements among medical schools and hospitals for research and training and for related demonstrations of patient care in these fields. It is also intended to afford to the medical profession and medical institutions through cooperative arrangements the opportunity to make available to their patients the latest advances and the diagnosis and treatment of these diseases and to improve generally the health manpower and facilities available.

MARMP

MSMS is fortunate in having as vice president of the Michigan Association for Regional Medical Programs, Inc. (MARMP) an active and dedicated physician, Don Marshall, MD, of Kalamazoo.

Federal Grants

Recently, announcement was made of the receipt of the first federal grant of over one million dollars under this program in Michigan, and other applications have been submitted and are awaiting approval from Washington.

Director of Mental Health

Mental Health Budget

Michigan now has a new director of the Department of Mental Health. Mental health in Michigan was one of the programs that had been affected during the period of the inability of the state to settle the problem of fiscal reform. At this date, it is too early to state that the Department will receive its full budgetary needs and requirements, and receipt of tax revenues will largely determine the scope and extent of this Department's activities for the coming year.

Community Mental Health Centers

President Johnson recently signed into law PL 90-31, the Mental Health Amendments of 1967. This law extends for three years the program of matching grants for the construction of community mental health centers and extends for two years the program of matching grants for assisting and defraying the costs of initial staffing. Another item in this act was an amendment of state plans providing that minimum state standards for these community centers must be in effect by July 1, 1969.

Departments of Public Health, Mental Health, Social Services

These items noted above are, presently, the more prominent of the government health programs. They are not by any means the major ones. The Department of Mental Health is largest in terms of money spent, facilities and personnel employed; the Department of Public Health is of greatest importance to the practicing physician because it is closest to him, "touching" him in the hospital, through the county health department, via surveys and statistics, with laboratory services, etc.

The Department of Social Services, with administrative responsibilities in Medicaid and Medicare, as well as through public-owned hospitals, has become a major factor in medical care. The interest of the State Department of Education in rehabilitation relates its work to medicine.

Military Medicine

Military medicine is important and becoming more so. Not only are many military installations located in Michigan, but the Veteran's Administration has major facilities here, and relationships with the military for the care of families of servicemen is a big program growing bigger.

Administrative Code

Final planning on machinery to add a new dimension of program (and service) to MSMS governmental activity by anticipating and helping to mold the rules and regulations of state agencies which will, when published as the Administrative Code, parallel the laws of the state, is under way.

A new subgroup of the Legal Affairs Committee will function within MSMS in a fashion similar to the Joint Legislative Committee on Administrative Rules. An MSMS staff man will have specific responsibility to regularly contact health-related agencies and seek out plans for development of rules and regulations; he will inform the Legal Affairs subgroup of these plans and assist the Society in effectively bringing medicine's thinking to the agencies involved.

When necessary, MSMS will make appearances before the Joint Legislative Committee itself. This activity will require extremely close liaison with the Attorney General Department, the Secretary of State Department, and the Legislative Service Bureau as well as with the several agencies and the Joint Legislative Committee.

We also plan to sharpen our reporting activity with regard to new health laws adopted (or new administrative rules and regulations) by articles in MICHIGAN MEDICINE of an analytical nature — e. g., what do the new laws actually provide? What effect will they have on (1) individual practice, (2) overall quality health care?

Government Importance

The significance of all of the above is simply this: *Government has become the largest and strongest single force in medicine in Michigan.* This is overwhelmingly so if medical education is considered part of "government."

Freedom to Practice Medicine

But to blindly thrash against the bonds that government appears to be fashioning for the profession is not the answer. Quite the contrary, it has the effect of making the bonds stronger and tighter. The only way to maintain the freedom

> ***"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."***
>
> *—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

and dignity of medicine is to be better informed, more alert, and more *unified* than medicine's would-be captors. It should be kept in mind that "government" is not a single unit but is many diverse units, each with separate jealousies, budgets, loyalties, responsibilities, etc. If the medical profession with its clear representation of the major purveyors of health remains unified, flexible, and active, it can call enough decisions so that it can maintain the freedom to practice so essential to its success and to its professional life.

Questions

A. What will be the effect on the medical profession of an increasing percentage of the gross amount spent for medical care being contributed by the governmental sector?

Percentage of Medical Care

B. What will the effect be on private practice when Public Health becomes more involved in medical care and the differences between public health and private health diminish?

Public Health and Private Care

C. How can the effect of Medicare and Medicaid (on the medical care given the people) be evaluated?

Evaluation of Medicare/Medicaid

D. What voids in preventive health exist that might encourage governmental programs to proliferate further?

Voids in Preventive Health?

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Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
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Bottles of 100, 500, 1000.

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Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
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Each Tablet Contains:
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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect Estrogen balances the androgen—only steroid effect remains Geriatrics, post operative and debilitating disease, osteoporosis **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month **CONTRA-INDICATIONS**: See Android Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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An anorectic will help her lose weight–
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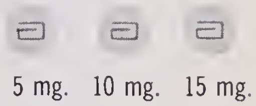
(even ours) to do that!

That's why Abbott offers you a pill plus a program.

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
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The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the secret of controlling your weight

Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

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To help you control your weight...

Please see Brief Summary on next page.

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Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Install Pollard to Lead College of Physicians

The 49th Annual Session of the American College of Physicians saw H. Marvin Pollard, M.D., Ann Arbor, installed as national president at the close of the scientific sessions at the War Memorial Auditorium in Boston.

Doctor Pollard, professor of internal medicine at the University of Michigan, heads the gastroenterology section at the U-M Medical Center. He was graduated from the U-M Medical School in 1931 and has been a member of the U-M faculty throughout his career.

He was active in the establishment of postgraduate education programs by the American College of Physicians in South America in 1963. In addition to his activities in the ACP, he serves as treasurer of the Organization of Gastroenterology and as director-at-large of the American Cancer Society.

ELECT CLAPPER TO SERVE ON BOARD FOR ACP

Muir Clapper, M.D., Detroit, Professor of Medicine at Wayne State University School of Medicine, has been elected to a three-year term on the Board of Governors of the American College of Physicians. Elections were held at the College's 49th Annual Session, recently in Boston.

WJBK-TV FILMS QUIZ

Herbert A. Raskin, M.D., of Detroit, one of the speakers at the recent MSMS Health Planning Conference, is shown here being interveiwed by Sylvia Wayne, of WJBK-TV, Channel 2 in Detroit, during the Conference. Doctor Raskin discussed Michigan state laws as they relate to problems of alcoholism and drug addiction.

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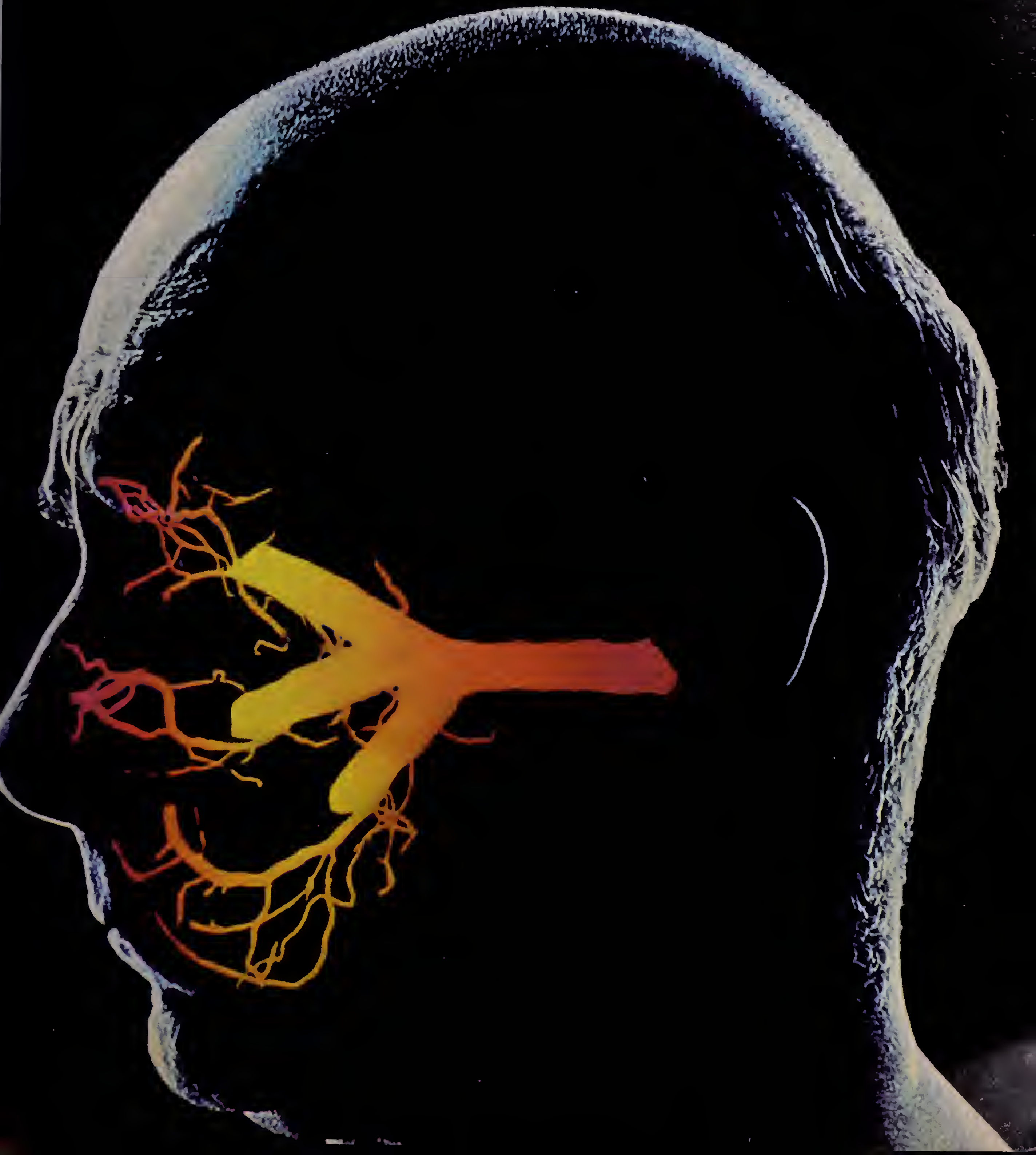
uncommon pain



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Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

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lorthalidone in edema and hypertension

Geigy

in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancre titis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reac tions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R2-46-230-D

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

New

Tegretol®
carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythem multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effect are drug-related is not known. However, some of these complications hav resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hour until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

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Geigy

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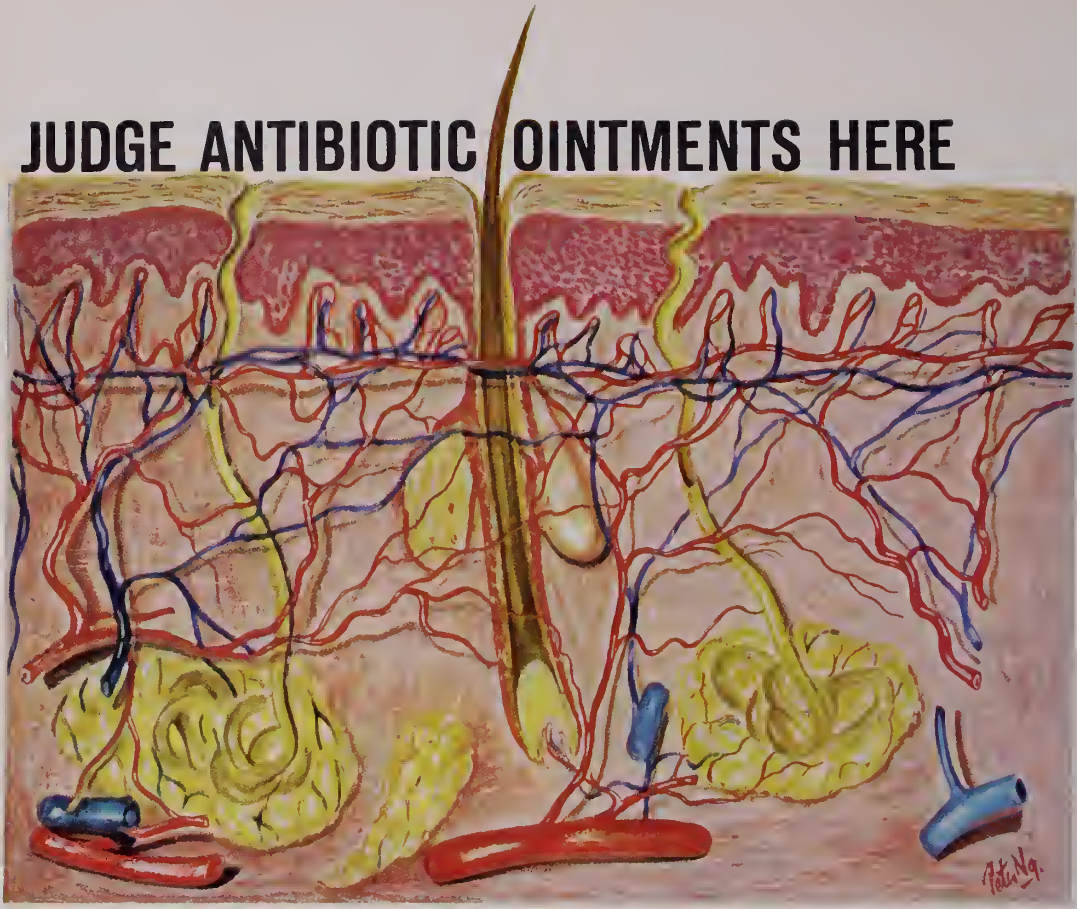

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

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State Reports Year Of PKU Testing

BY MICHIGAN DEPARTMENT OF PUBLIC HEALTH

During the 1967 phenylketonuria testing program, the total number of Guthrie tests performed on newborns in 204 hospitals in Michigan was 157,583. The total number of births in Michigan during 1967 was 161,637. There was a total of 107 presumptive positive tests. Thirteen newborn infants with PKU were identified, bringing the incidence rate for Michigan in 1967 to one in approximately 12,000 live births.

The relatively large number of presumptive positive tests is worthy of mention. Most of them occured in infants of low birth weight, particularly infants receiving high protein feedings. A number of infants who initially presented low grade but persistent elevations of blood phenylalanine, on the other hand, eventually had the diagnosis of atypical or "mild" PKU confirmed. For this reason, all infants with presumptive positive tests received very careful follow-up.

David W. Knox, M.D., left, intern at Midland Hospital, received a $1,000 Mead Johnson award for Graduate Training in General Practice during the Annual MSMS Spring Clinic in Midland. Presentation was made by Lee Feldkamp, M.D., right, Plymouth, president of the Michigan Academy of General Practice. Doctor Knox received his M.D. degree from Ohio State University College of Medicine in 1967 and is now completing his first year of family practice training in Midland Hospital's program. The scholarship award is one of 12 granted annually by the American Academy of General Practice under a grant from Mead Johnson Laboratories. Charles A. Sanislow, M.D., seated center, Midland, was chairman of the day. A. Carl Stander, M.D., MSMS councilor, and Robert E. Bowsher, M.D., Director of Medical Education at Midland Hospital, assisted with the arrangements for the MSMS postgraduate educational program.

PKU DIET BOOKLET REVISED

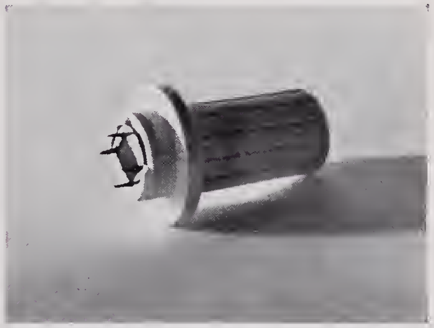
A revised edition of the booklet "The Low Phenylalanine Diet" is now available. This revision replaces the two previous publications "The Low Phenylalanine Diet — for Professional Use" and "A Diet Guide for Parents of Children with PKU." It is printed with a washable plastic cover and is spiral bound so that it may be used by the mother while actually preparing food in the kitchen. It has been developed by the Nutrition Section, Michigan Department of Public Health, with the cooperation of other institutions, agencies, and commercial companies.

The booklet has been prepared as a working guide for the parent, and includes information of the disease, and the steps involved in planning the diet according to the physicians prescription. More emphasis is placed in this booklet on the diet of the newly-diagnosed *infant* along with guidance for the parent in making the transition in feeding from infancy to toddler stage.

Copies of this booklet are available free within the State of Michigan and may be requested from the Nutrition Section, Michigan Department of Public Health, Lansing, Michigan 48914.

To fight TB-find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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ACTIVITIES, PROJECTS

DOCTORS, WIVES FURNISH KIMBALL MUSEUM ROOM

The Woman's Auxiliary to the Calhoun County Medical Society is furnishing the Medical Room of the historic Kimball House Museum in Battle Creek.

Originally belonging to the late Arthur Kimball, M.D., the house was given to the Junior League of Battle Creek for development as a museum.

The Calhoun County Medical Society has donated $900.00 to the Woman's Auxiliary to paint and furnish the Medical Room.

Francis L. Lam, M.D., president of the Calhoun County Medical Society, reports that the equipment in the room dates back to about 1870. It includues an examining table, surgical instruments, an antique rocker, and a microscope.

"One of the interesting items," Doctor Lam said, "is an old doctor's ledger. It contains reference to physician's fees being paid with a cord of wood or two chickens." ☐

US SURVEY POINTS TO DANGERS OF SMOKING

The new U.S. Public Health Survey of smoking-health has reported the following findings about the harmful effects of smoking:

Members of the nation's labor force who smoke cigarettes spend some 33 per cent more time away from work because of illness than do persons who have never smoked.

Women who smoke cigarettes, including both housewives and those who work outside the home, spend 17 per cent more days ill in bed than women who have never smoked.

In addition, people who smoke have more days in which they have to cut down on their usual activities because of illness.

The relationship between smoking and illness is particularly strong for such diseases as chronic bronchitis, cardiovascular disease, and peptic ulcers. What has long been known about the relationship between smoking and death from these diseases is now shown to be true of illness and disability as well. ☐

Jaycees Sponsor Many Local Health Projects

Through their continuing concern for Community Development, Michigan Jaycees have been active in various health issues around the state. VD education, measles innoculation, and fluoridation — these are just a few of the areas in which this dynamic group has been involved.

The Livonia Jaycees launched a measles innoculation program. The Wayne County Medical Society helped by providing a doctor, two nurses, and two technicians. American Red Cross provided clerical help and Bank of Detroit supplied a teller to handle donations.

The Fremont Jaycees, with the help of the Newaygo County Medical Society and the county dental association and other groups, got the public support necessary for the City Commission to approve fluoridation of city water.

The Fowler Jaycees piloted a VD education project in Clinton County by presenting 28 programs to various community organizations thereby awakening the public to the need for VD education among young people and teen-agers.

Mount Clemens Jaycees are taking leadership in Project Showboat. Aim of this program is to raise $112,000 to buy a houseboat and convert it to a small floating clinic for use on the Mekong River in Southeast Asia by the Thomas A. Dooley Foundation. The clinic will help local people establish their own basic care centers. ☐

OAKWOOD DIRECTOR CITED

Neil McGinniss, director of Oakwood Hospital, Dearborn, recently received the Key Award, highest honor conferred by the Tri-State Hospital Assembly, during the annual meeting in Chicago. Mr. McGinniss, a past president of the Michigan Hospital Association, is in his eleventh year as director of Oakwood Hospital. ☐

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How About Anti-Smoking Poster for Office Display?

An excellent poster which reads "1,000 Doctors Have Quit Smoking Cigarettes (maybe they know something you don't)" has been issued recently by the National Clearinghouse on Smoking and Health.

Any physician who would like to receive one, or a supply of them, can get them from MSMS headquarters, P.O. Box 152, East Lansing. ☐

WSU MAN SELECTED AS MARKLE SCHOLAR

Robert F. Wilson, M.D., assistant professor of surgery at Wayne State University School of Medicine, has been named a Markle Scholar by the Markle Foundation in New York. To promote his professional development, Doctor Wilson will receive a $30,000 grant over a five-year period.

Doctor Wilson received his medical degree from Temple University, and has served on the Wayne faculty since 1963. His research has been in the basic mechanisms of shock and other metabolic derangements in humans. ☐

One of the sidelights to the 1968 WSU Medical School Alumni Clinic Day in Detroit recently was a special art exhibit composed of work by alumni physicians and their wives. Discussing one of his works with Mary Sylvester, a reporter from the Royal Oak Daily Tribune, is Joseph R. Montante, M.D., of Orchard Lake. Thirty physicians and their spouses contributed 70 pieces of art. The show was coordinated and hung by David Jacknow, M.D., of Huntington Woods.

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PUBLIC RELATIONS

Counties Invited to Join Community Health Week

BY BROCK E. BRUSH, M.D., CHAIRMAN
MSMS COMMITTEE ON PUBLIC RELATIONS

Every component medical society in Michigan is encouraged to join the MSMS observance of the 1968 Community Health Week, October 20-26.

Three timely themes — drug abuse, physical fitness and health careers — have been selected by the AMA for this sixth annual observance of Community Health Week across the nation. Community Health Week is a public service program inaugurated by the AMA's House of Delegates in 1962.

Goals of the observance are for state and county medical societies, in cooperation with other members of the community health team, to present meaningful programs aimed at furthering public awareness of the wide variety of health services and facilities existing at the community level, to call attention to present health problems and potential solutions, and to call attention to continuing medical advances.

Your MSMS Committee on Public Relations will propose possible county-level projects, and offer advice and guidance. ☐

Urges Better Evaluation Of Health Messages

BY PETER HOHEISEL
OF THE MSMS STAFF

"What is often called evaluation of health education is only a description of activity rather than outcomes," said a University of Michigan psychologist at a panel on "Psychological Influences on Health Behavior" during the AMA's recent 3rd National Conference on Health Education of the Public in Chicago.

Speaking on "Health Education Research Relating to Health Behavior," James W. Swinehart, Ph.D., a research associate and lecturer in the U-M School of Public Health, noted three basic needs in health education today: (1) To reduce the discrepancy between belief and behavior, (2) To obtain and use more information on audience characteristics when planning health education programs, and (3) To do more and better evaluation of health education efforts.

Doctor Swinehart described the process through which a health education message is transmuted from information to action as six basic steps: Distribution, Exposure, Attention, Learning, Acceptance, and Action.

"If there is a gap between any of the six steps," Doctor Swinehart explains, "the desired action may not take place. A person could go through the first five without taking the last and most important step to action."

"There has been an assumption on the part of health educators and physicians that if you give people information they will act rationally on it," he continued.

"Several studies have shown that this is not the case," the University of Michigan Psychologist said.

Doctor Swinehart cited a study of policemen in California as to whether or not they use seat belts when driving their own automobiles. The assumption would be that as a segment of the population they would have a higher consciousness of the importance of the seat belt since they see the results of accidents when people are not wearing them and since they are required to wear them in their own patrol cars. The study, however, did not show any higher incidence of the use of seat belts among policemen.

To close the gap between information and action, Doctor Swinehart recommends more detailed research into the specific characteristics of the audience which is to be reached with a health message.

He recommends that health educators find out "What kind of worries do people have about specific diseases. Is it the pain? The cost of treatment? The attitudes of other people toward the disease?"

"Once these and other matters are determined with some precision," Doctor Swinehart said, "A message can be tailored to a specific audience segment, and, in my opinion, be much more effective. If we can get a better idea of who the audience is, we can know more definitely that the 6 steps will take place." ☐

DID YOU KNOW THAT

"Would-be doctors entering medical school this fall may be astonished to learn that 80 per cent of the medical practice they will be taught was discovered since most of them were born."

— American Education
Journal of HEW
March 1968

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A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
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Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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BROWN SPIDER MOVING NORTH; SYMPTOMS ARE EXPLAINED

(Note: The following are excerpts from a National Clearinghouse for Poison Control Centers Bulletin distributed in Michigan by the Division of Epidemiology, Michigan Department of Public Health.)

Although the brown spider has been recognized to exist in most parts of Oklahoma, Kansas, Arkansas, Texas, Louisiana, Mississippi, Alabama and Tennessee, reported activities would indicate a northward migration of the species.

A three-year-old boy living in Pocahontas, Illinois died two days after having been bitten by a spider in bed; a *Loxosceles reclusa* was found in the home.

The brown spider varies from $\frac{3}{10}$ to $\frac{1}{2}$ inch in body length and is yellowish to dark brown in color. This spider is distinguished by the presence of three pairs of eyes arranged in a semi-circle on the fore part of the head and a violin-shaped dark marking on the cephalothorax immediately behind the semi-circle of the eyes.

The spider is usually found in dark spaces and its irregular webs are spun near cracks in foundations and in or around steps, containers, or hanging clothes. The spider is not considered to be aggressive and most bites have occurred when spiders were trapped beneath clothing or bedding.

The systemic symptoms are fever, restlessness, albuminuria and generalized pruritic rash (scarlitiniform) over the entire body. The toxin has been shown both experimentally and clinically to produce acute hemolytic anemia with hemoglobinuria and hematuria. Jaundice occurs in about 33% of the patients. The systemic effects may last up to five days and may result in the patient's death. The local reaction is of inflammation discoloration, echymosis, necrosis, and tissue sloughing which may persist for several weeks. A local reaction is the most common and, except for its prolongation, is usually relatively benign. The treatment is symptomatic and supportivve, but steroids and antihistomines may be of value.

Useful references on the subject of the *Loxosceles reclusa* are: James et al, Am. J. Dis. of Child., Sept. 1961, pp. 145-148; JAMA, 185-11, Sept. 1963, Arachnidism in the United States, pp. 839-843; Schreiner, G. F. and Maher, J. F., Toxic Nephropathy, Am. J. of Med., 38:438, March 1965; Nation Pest Control Association—Technical release No. 11-64, June 24, 1964, No. 11-58, June 17, 1958.

Florida, Michigan Lead Nation in Growth In Personal Income

Herbert C. Dejonge, Director, Department of Commerce of the State of Michigan, made the following observations about Michigan's economic health in his article "Michigan Expanding Economy" which appeared in a recent issue of *Michigan Challenge*.

So far in the decade of the 60's Michigan ranks second among the largest states in percentage growth for total personal income.

Since 1962, Gross State Product — the total output of goods and services — jumped 50.6% while gross national product is up 40.2%. Nonfarm employment in the State climbed from 2,672,000 to 3,168,000 or 18.6%; the U.S. average gain was 13.9%.

Since 1963, retail sales in Michigan have jumped 33.6%, versus a rise of 27.1% for all states.

THE 10 LEADING STATES IN TERMS OF INCREASE IN PERSONAL INCOME
(in millions of dollars)

	1960	1966	Change	% Increase
Florida	9,746	15,410	5,664	58.1
Michigan	18,203	27,685	9,482	52.0
California	42,980	65,002	22,022	51.2
Indiana	10,225	15,230	5,005	48.9
Texas	18,535	27,319	8,784	47.4
New Jersey	16,528	23,767	7,239	43.8
Illinois	26,718	38,089	11,371	42.6
Ohio	22,729	31,670	8,941	39.3
New York	46,281	63,669	17,388	37.6
Pennsylvania	25,395	34,434	9,039	35.6

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* 1904 - 1967

Auxiliaries Collect Drugs, Supplies for Overseas

BY MRS. W. G. GAMBLE, JR., PRESIDENT
WOMAN'S AUXILIARY TO MSMS

International Health Activities is a most important Auxiliary program, for it is dedicated to helping the less fortunate persons of our own and other nations. Through our national, state, and local International Health Activities committees, we are attempting to ease the critical shortage of medical supplies throughout the world.

Our method is simple — the Auxiliary at the county level collects unused supplies and sends them to a proper distribution agency (one that is certified by the U.S. Food and Drug Administration) for shipment to foreign countries. In Michigan the supplies go to World Medical Relief, a certified agency whose headquarters are in Detroit.

WHAT DO WE COLLECT?

Pharmaceutical samples are a major item for collection. However, they must be in perfect condition and up-to-date. A registered pharmacist at World Medical Relief checks all medications before they are distributed to foreign recipients.

Another commodity we collect is medical textbooks which must be at least four years current. Medical and surgical supplies, treadle sewing machines, prostheses of every description, medical journals, used radio equipment for physicians in remote areas, eye glasses (both lenses and frames, and not necessarily together) are all valuable materials which are needed in underprivileged areas here and abroad.

But not only do we collect items such as the ones listed above — we also make useful articles. For instance, if you attended a meeting of the Auxiliary in your county, you would see many members knitting seemingly endless, three-inch or one-inch-wide bands. These knitted bands, after being carefully washed, dried, and wrapped in plastic, become leper bandages. Other bandages are made from old sheeting or pillow cases.

Johnny Coats are another Auxiliary-produced article. They are made from old shirts and are used for hospital gowns by needy persons all over the world.

HOW LARGE AN EFFORT is this project for international health? Some statistics answer the question: In 1966-67 the Auxiliary to the MSMS sent 15,337 pounds of drugs and many large pieces of equipment to World Medical Relief. In addition, approximately 1000 pounds of materials were sent to World Vision. This year's poundage is even more impressive. Over 30,000 pounds of medical supplies have been collected thus far, this year, for the International Health Activities program. Of course this does not include approximately $500 that has been donated to the cause of international health.

This year's state chairman for IHA is Mrs. R. F. Hauer of Fowlerville. Mrs. Hauer joins me in requesting that you physicians continue helping us, by contributing surplus supplies, to help others.

In this way we can all show our concern for our less fortunate neighbors.

APHA Convention In Detroit to Focus On Urban Questions

The urban health crisis and health planning are two of the major items the 96th annual meeting of the American Public Health Association will study at its November 11-15 meeting at Cobo Hall in Detroit.

Current APHA president and chairman of the local committee for the annual meeting is John J. Hanlon, M.D., Detroit and Wayne County Director of Public Health.

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MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING MAY 31, 1968

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	45	149	202	790
Whooping Cough	25	95	211	480
Diphtheria	0	0	0	0
Mumps	2432	2379	11808	10512
Scarlet Fever & Strep Sore Throat	1001	1225	6105	8296
Tetanus	1	1	2	1
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	272	185	883	931
Salmonellosis (Other than S. Typhi)	67	45	272	227
Typhoid Fever (S. Typhi)	0	0	0	4
Shingellosis	22	78	93	233
Aseptic Meningitis	4	3	24	9
Encephalitis	16	14	47	47
Meningococcic Meningitis	11	8	48	33
Influenzal Meningitis	6	8	25	21
Tuberculosis	225	271	1217	1306
Syphillis	546	546	2458	2593
Gonorrhea	1518	1627	7065	6909

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Breathalyzer Effective In Michigan

BY ELMER WHITE, EXECUTIVE DIRECTOR, MICHIGAN PRESS ASSOCIATION

The old slogan, "If you drink, don't drive," may soon be obsolete as Breathalyzers become more common in Michigan. The new slogan seems to be, "If you drink and drive, be prepared to walk."

Arrests for drunk driving increased 78 percent the first four months of 1968 over 1967, Michigan State Police report. Law enforcement agencies throughout the state, from January through April, asked 5,151 drivers to take the test. Seventy-six percent of those tested exceeded the presumptive level of intoxication, and 12% were in the "impaired driving" bracket. Police said 1,214 drivers refused to take the test.

Under Michigan's "Implied Consent Law," refusal is cause for suspension of an operator's license. Secretary of State James M. Hare reports that 1,236 drivers cited for refusing to take the chemical test, 631 persons appealed the license suspension. Licenses were restored, after hearings, in 95 cases and denied in 524; 12 cases were awaiting hearing dates.

There are now 850 Breathalyzer operators in the state, and another 100 will be trained before the current school is completed, State Police say. Instruments have been placed in 40 sheriff offices, 39 city police departments, three township police departments and 59 State Police posts. Forty-seven more will be installed in the near future.

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IN MEMORIAM

R. M. Cooley, M.D., Jackson

Randall M. Cooley, M.D., Jackson radiologist, died May 20. He was 81. Doctor Cooley was a Life Member of MSMS and a Past President of the Jackson County Medical Society. He was affiliated with Mercy Hospital, Jackson.

His premedical studies were done at Kalamazoo College and he was graduated from the University of Michigan Medical School in 1910. He served at the 125th Field Hospital during World War I.

He was president of the Detroit Roentgen Ray and Radium Society in 1956 and was a member of the Radiological Society of North America and the American College of Radiology.

H. F. Dibble, M.D., Detroit

Harry F. Dibble, M.D., Detroit, a delegate to the MSMS House of Delegates from Wayne County for many years, died May 10. He was 79.

Doctor Dibble was a member of the House of Delegates between 1920 and 1950 and served several years on the MSMS News Committee at the Annual Sessions when held in Detroit. He held a teaching appointment in general surgery at Wayne State University from 1921 to 1950.

He was graduated from the Detroit College of Medicine in 1911 and served his internship and residency at Harper Hospital. He was affiliated with Harper and Receiving hospitals until his retirement.

During World War I, he served briefly with the Royal Army Medical Corps and as a Captain in the Medical Corps of the U. S. Army, Base Hospital, France.

Doctor Dibble was a Fellow of the American College of Surgeons, a Life Member of MSMS, and a member of the Academy of Surgery and the Detroit Surgical Society. His medical fraternity was Nu Sigma Nu.

N. H. Goldberg, M.D., Detroit

Nathan H. Goldberg, M.D., Detroit physician, died May 4 at the age of 76.

Doctor Goldberg was graduated from the Vanderbilt University School of Medicine in 1916.

He had practiced in Detroit for the past 35 years, specializing particularly in urology, syphilology, dermatology and surgery. He was affiliated with Wayne County General Hospital.

He was a Life Member of MSMS and a member of Pi Mu medical fraternity.

Joseph Hickey, M.D., Dearborn

Joseph Hickey, M.D., Dearborn general practitioner, died April 12 at the age of 71.

Several times a delegate from Wayne County to the MSMS House of Delegates, Doctor Hickey was a Life Member of MSMS.

He received the M.D. degree from Wayne State University in 1929 and did his residency and internship at Receiving Hospital, Detroit. He served as chief of staff at Oakwood Hospital, Dearborn, from 1954-56 and was also affiliated with Delray General Hospital, Mt. Carmel Mercy and Wyandotte hospitals.

Doctor Hickey was an Associate Fellow of the International College of Surgeons and a member of the American Academy of General Practice and Phi Beta Pi medical fraternity.

G. W. Stewart, Jr., M.D., Saginaw

George W. Stewart, Jr., M.D., Saginaw general practitioner, died May 13 at the age of 58.

Doctor Stewart began practice in Saginaw in 1941 after two years in Owosso. At various times he served as president, vice-president and secretary of the Senior Staff at St. Lukes Hospital in Saginaw. He was also affiliated with St. Mary's Hospital and Saginaw General Hospital.

He received the B.A. degree from the University of Detroit and was graduated from the University of Michigan Medical School in 1937. For four years during World War II he served in the Army Medical Corps and was awarded two Battle Stars for action in the Pacific Theatre.

Doctor Stewart was president of the Saginaw Academy of General Practice in 1953.

SERVICE TO HANDICAPPED, TRIBUTE TO ALMA DOCTOR

A sheltered workshop program for the Central Michigan area soon to be inaugurated in Alma will be a living memorial to the late C. L. Hoogerland, M.D., an Alma physician and pediatrician who died a few years ago. To be known as the C. L. Hoogerland Memorial Workshop, the project will assist the physically, emotionally, and mentally handicapped by providing training and an opportunity to work under sheltered conditions. It will also help to find employment for those who may be able to leave the workshop to accept full-time employment in the community.

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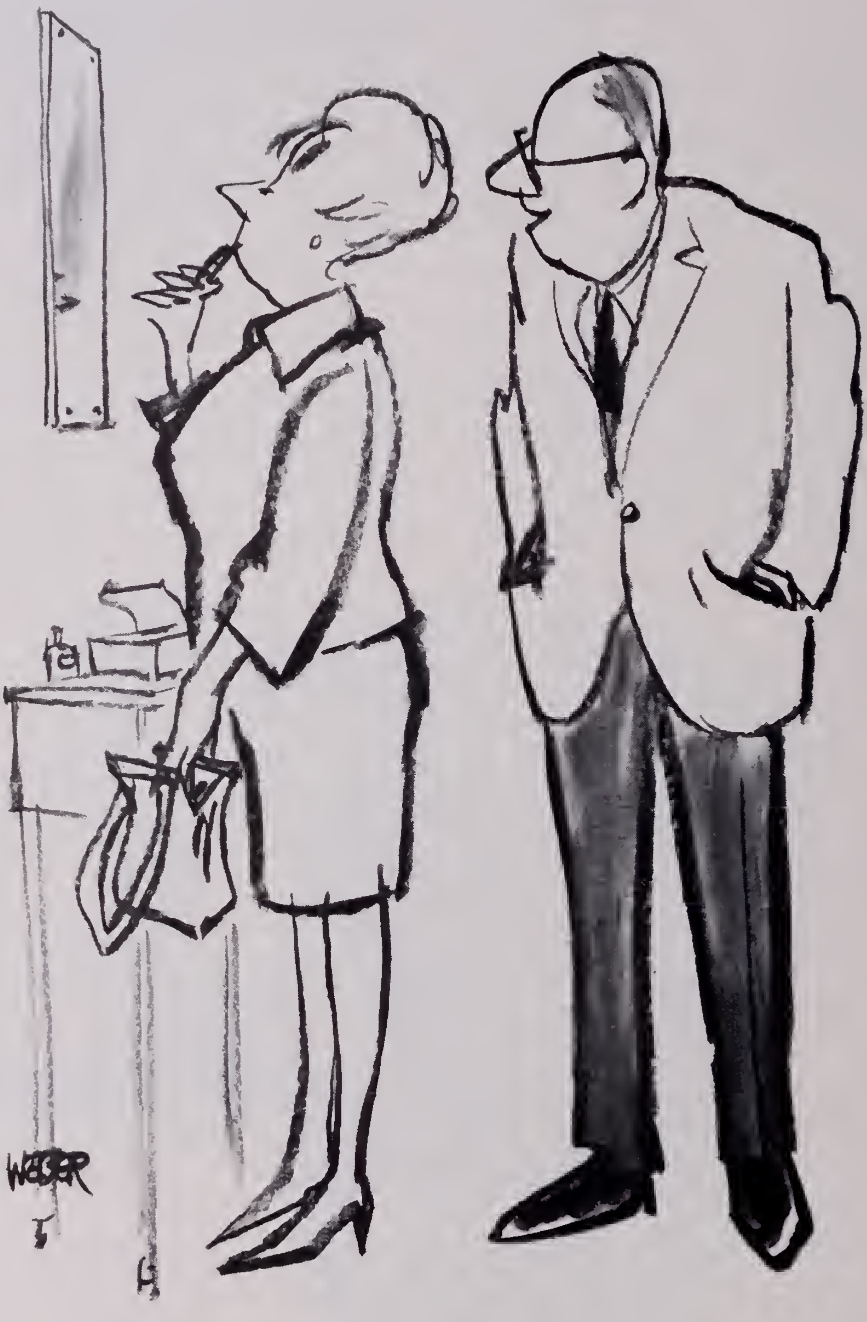

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Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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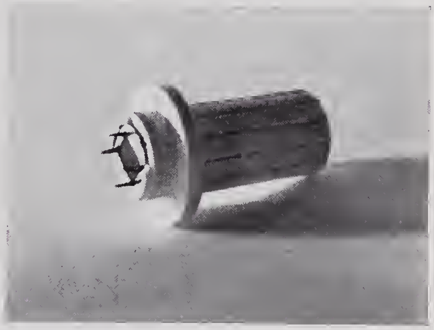

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Ralph Blocksma, M.D., Grand Rapids,

visited the Dominican Republic and was received by president Dr. Joaquin Balaguer. He was honored for the efforts made by the Medical Assistance Program of which Doctor Blocksma is chairman, to reduce infant mortality in the Dominican Republic.

Bonnie R. Wolfram, M.D., Detroit,

participated in the National Budget and Consultation Committee Meetings in New York, held annually to review budget requests from national agencies in federation, supported by United Funds.

Chester S. Koop, M.D., Flint,

is the new president of the Genesee County Tuberculosis and Respiratory Disease Association.

James C. Cook, M.D., Detroit,

clinical associate professor at WSU, has been named a delegate of the American Roentgen Ray Society to the International Congress of Radiology in Tokyo in October, 1969.

Edward D. Sage, M.D., Kalamazoo,

recently celebrated his 90th birthday and announced his plans to retire after 66 years of active practice in the community. He received a citation from the Latvian Lutheran church.

Three Michigan doctors

presented papers at the meeting of the American College of Surgeons held in Munich in cooperation with the German Surgical Society. They are Robert W. Bailey, M.D., Ann Arbor, Reed O. Dingman, M.D., Ann Arbor, and James M. Pierce, Jr., M.D., Detroit.

Harold L. Upjohn, M.D., Kalamazoo,

has been named Vice President of the Upjohn Company in charge of Medical Affairs. He had been Director of Medical Research for the company since 1962.

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Frederick Van Duyne, M.D., Flint,

was elected a delegate to the Republican National Convention from Michigan's 7th District. Also chosen at the Republican State Convention were Donato Sarapo, M.D., Adrian, alternate delegate from the 2nd District and Jack M. Stack, M.D., Alma, alternate delegate from the 10th District.

Harry A. Towsley, M.D., Ann Arbor,

has been appointed to the Board of Trustees of Northwood Institute in Midland.

Raymond W. Waggoner, M.D., Ann Arbor,

has been honored by two medical groups. The American College of Psychiatrists presented the E. B. Bowis Award for 1968 to him at the annual meeting of the College in Boston in recognition of his "outstanding achievements, contributions, and leadership in the field of psychiatry." A special Resolution of Appreciation by the Michigan Society for Mental Health expressed esteem and lauded him for his many years of service to the mentally ill in Michigan.

James J. McClendon, M.D., Detroit,

has been appointed president of the Detroit Board of Health.

Willard Hayes, M.D., Norway,

was honored at a public dinner at which he received the 1968 "Citizen of the Year" award given by the Iron Mountain Lions Club for outstanding humanitarian and civic endeavors.

J. Daniel Cline, M.D., Midland,

was chosen "Citizen of the Year, 1968" by the Midland Civitan's Club for his "unselfish civic service and the promotion of good citizenship by example, and specifically for his work with young people and the promotion of interest and excellency in athletics."

Morley B. Beckett, M.D., Ann Arbor,

has been named Doctor Director Emeritus of the University Health Service and Professor Emeritus of Community Health Service by the Regents of Alumni of the University of Michigan. He was director of the university health service and professor of public health from 1955 until his retirement this year.

E. F. Arscott, M.D., Rogers City,

will soon be leaving his private practice to become assistant medical director of the Ford Motor Company, Cleveland.

VOLUME 67, NUMBER 14 • JULY 1968 • DEADLINE FOR COPY, JULY 29, 1968

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

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See Program Inside for '68 Annual Session

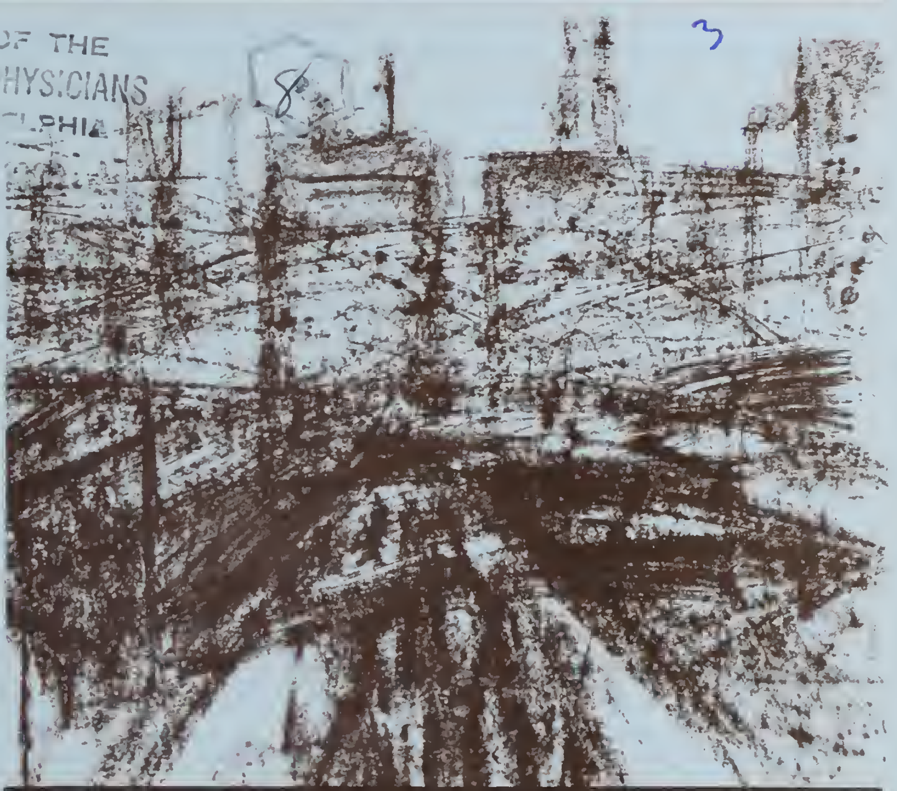
Early response to the program for the 1968 MSMS Annual Scientific Session has been enthusiastic. Physicians have commented upon the timeliness of the topics and the high quality of the medical authorities obtained for the Annual Session, September 25-26 in Detroit.

A program — more in detail than the early one last month — appears in this issue.

Every MSMS member is urged by MSMS President Bradley M. Harris, M.D., to decide now to participate in the excellent postgraduate experience. Doctor Harris praises the work of the Annual Scientific Session Program Committee and Alexander J. Walt, M.D., Detroit, the chairman.

The 1968 Scientific Session on Wednesday and Thursday, September 25-26, will follow the annual House of Delegates meeting, which again will extend from Sunday night, September 22 through the annual election on Tuesday night, September 24.

Joining MSMS again in Detroit will be the Woman's Auxiliary to MSMS, which will be in session September 24-25-26, and the Michigan State Medical Assistants Society, which will confer on September 25-26.



Urge Every MSMS Member Attend September 25-26

The 1968 Scientific Program offers General Sessions, MSMS Section Programs, Four All-Day Postgraduate Courses, Meetings of Medical Specialty Organizations, Fireside Discussions, Exhibition Hall, and other educational events.

A review of the Program, on the inside pages of this issue of *Michigan Medicine,* will show that 22 MSMS Sections and 8 Specialty Societies will hold scientific sessions during the MSMS Annual Session.

Members of the Michigan Academy of General Practice will receive credit for each hour they attend the 1968 Annual Session. Application for approval should be made to James Dooley, M.D., Chairman, Commission on Education, 3210 S. Dort Highway, Flint.

Master Timetable for MSMS Activities In Detroit for Week of September 22

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Sunday, September 22

Meeting of MSMS Council

Delegates Workshop

Speakers' Dinner (For Reference Committee Chairmen)

MSMS House of Delegates Convenes

* * *

Monday, September 23

MSMS House of Delegates

Reference Committee Meetings

* * *

Tuesday, September 24

MSMS House of Delegates

Reference Committee Meetings

Michigan Medical Service Members Meeting

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Delegates Dinner and Installation of President

* * *

Wednesday, September 25

MDPAC Breakfast

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Michigan State Medical Assistants Society Annual Meeting (Pontchartrain Hotel)
- House of Delegates
- Presidents Luncheon
- Annual Banquet

MSMS Exhibition of Technical Displays

MSMS Scientific Program
- Breakfast Roundtable Discussions
- Postgraduate Courses (All-Day Seminars)
  - Infectious Diseases
  - Pulmonary Diseases
- Panel Discussions and Assembly Presentations
  - Breast Carcinoma
  - Abdominal Arteriography
  - Problems of the Fetus
  - Trauma
  - Pediatric Problems
  - Relief of Pain
- General Luncheon (With Special Speaker)
- Fireside Discussions with Speakers

Section Meetings and Special Programs
- Allergy and Applied Immunology
- Anesthesiology
- Dermatology
- General Practice
- Obstetrics and Gynecology
- Ophthalmology
- Otolaryngology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Public Health and Preventive Medicine
- Radiology
- Surgery

Specialty Society Cooperating Groups
- Detroit Roentgen Ray Society
- Michigan Society of Anesthesiologists

* * *

Thursday, September 26

Reorganizational Meeting of The Council

MSMS Exhibition of Technical Displays

Woman's Auxiliary Annual Meeting (Statler-Hilton Hotel)

Michigan State Medical Assistants Society Annual Meeting (Pontchartrain Hotel)
- Educational Program
- Installation Luncheon

Thursday, September 26, Continued

MSMS Scientific Program

- Breakfast Roundtable Discussions
- Postgraduate Courses (All Day Seminars)
  - Blood Diseases
  - Digestive Diseases
- Panel Discussions and Assembly Presentations
  - Cardiovascular Diseases
  - Prostate Carcinoma
  - Calcium — Too Much, Too Little
  - What's New in Practice of . . .
    - Cardiovascular Disease
    - Cancer
    - Transplantation
    - Urology
    - Gynecology
    - G-I Tract Diseases
    - Infection and Antibiotics
    - Pediatrics
    - Endocrine Diseases
  - Diabetes
  - Psychiatric Problems of Aging Population
- General Luncheon
  - Special presentation on "Organ Transplantation"

Section Meetings and Special Programs

- Anesthesiology
- Internal Medicine
- Occupational Medicine
- Orthopedic Surgery
- Neurological Surgery
- Pathology
- Proctology
- Psychiatry and Neurology
- Thoracic Surgery
- Urology

Specialty Society Cooperating Groups

- Detroit Urological Society
- Michigan Diabetes Association
- Michigan Orthopaedia Society
- Michigan Society of Anesthesiologists
- Michigan Society of Neurological Surgeons
- Michigan Society of Pathologists
- Michigan Society of Psychiatry and Neurology

> ***"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."***
>
> *—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

1968 Annual Session Program

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Wednesday Morning, September 25

7:30- 8:45 a.m. **Breakfast Roundtable Discussion on Obstetrics-Gynecology**
Sponsored by Section on Obstetrics and Gynecology
Use of the Laparoscope
Alfred I. Sherman, MD, Wayne State University

8:45- 5:00 p.m. **All-Day Postgraduate Course on Infectious Diseases**
By advance registration only

MORNING:

Moderator: A. Martin Lerner, MD, Wayne State University

9:00- 9:45 a.m. New Virus Vaccines (Respiratory, Measles, Mumps)
Jerome O. Klein, MD, Harvard Medical School

10:00-10:45 a.m. Extended Rubella Syndrome and Its Prophylaxis
Mary M. Carruthers, MD, Chicago Medical School

11:00-11:45 a.m. Interferon and Its Clinical Application
Thomas C. Merigan, MD, Stanford University School of Medicine

AFTERNOON:

Moderator: Harry F. Dowling, MD, Chicago

2:00- 2:45 p.m. Antiviral Chemotherapy
Jerome A. Gold, MD, Woman's Medical College of Pennsylvania

3:00- 3:45 p.m. New Antibiotics Versus Gram-Negative Infections Including the Penicillins, Cephalosporins, Tetracyclines and Gentamycin
Edward L. Quinn, MD, Ford Hospital, Detroit

4:00- 4:45 p.m. Special Toxicities of Older Antibiotics, Tetracycline, Kanamycin, Colistin
Frank Cox, MD, Ford Hospital, Detroit

8:45- 5:00 p.m. **All-Day Postgraduate Course on Pulmonary Diseases**
By advance registration only
Chairman: Geoffrey L. Brinkman, MD, Wayne State University

MORNING:

Benjamin M. Lewis, MD, Moderator, Wayne State University
Management of Respiratory Failures

8:45 a.m. Clinical Manifestation
Kaye H. Kilburn, MD, Duke University Medical Center

9:10 a.m. Physiology of Respiratory Failure
Benjamin M. Lewis, MD, Wayne State University

Treatment

9:50 a.m. Maintenance of a Clear Airway
Kaye H. Kilburn, MD, Duke University Medical Center

10:20 a.m. Use of Oxygen
Gordon L. Snider, MD, Boston University School of Medicine

11:00 a.m. Ambulatory Care
Thomas L. Petty, MD, University of Colorado Medical Center

11:30 a.m. Panel of Five Course Lecturers

AFTERNOON:

Moderator: Geoffrey L. Brinkman, MD, Wayne State University

Pulmonary Embolism

2:00 p.m. Diagnosis — Clinical
Thomas L. Petty, MD, University of Colorado Medical Center

2:15 p.m. Diagnosis — Radiological
Manuel Viamonte, MD, University of Miami School of Medicine

2:45 p.m. Therapy — Medical
Kaye H. Kilburn, MD, Duke University Medical Center

3:00 p.m. Therapy — Surgical
Rodman Taber, MD, Ford Memorial Hospital, Detroit

Acid-Fast Infections

3:45 p.m. Atypical Acid-Fast Infections
Gordon L. Snider, MD, Boston University School of Medicine

4:20 p.m. Prophylactic Anti-Tuberculosis Chemotherapy
Wintrop N. Davey, MD, University of Michigan

9:00-Noon **Breast Carcinoma: General Session**

Moderator: Alexander J. Walt, MD, Wayne State University

9:00 a.m. The Problems and Aspects of Cure — Mammography and Xerography
John A. Wolfe, MD, Wayne State University

Indications and Results of Chemotherapy in the Management of Breast Cancer
Vainutis K. Vaitkevicius, MD, Wayne State University

10:45 a.m. Aspects of Palliation — Surgical Aspects
William J. Fry, MD, University of Michigan

The Place of Radio Therapy in Carcinoma of the Breast
Doctor M. Betty Bennett, University of Capetown, So. Africa

11:30 a.m. Approach to Surgery of the Potentially Curable Case
Cushman D. Haagensen, MD, Columbia University College of Physicians and Surgeons

William L. Donegan, MD, University of Missouri School of Medicine

9:00-10:00 a.m. Selective Abdominal Arteriography: General Session
Moderator: Roger L. Rian, MD, Ford Hospital, Detroit

Angiography in Liver Diseases, Splenic Pathology, Pancreatic Gastric, Small and Large Bowel and Renal Diseases
Manuel Viamonte, Jr., MD, Univ. of Miami School of Medicine

1968 Annual Session Program-Continued

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Wednesday, September 25 — Continued

10:45-Noon **Problems of the Fetus: General Session**

Title to be selected
Robert Usher, MD, Royal Victoria Hospital, Montreal

Pre and Postnatal Resusitation
John P. Harm, MD, Wayne State University

Noon-2:00 p.m. **General Luncheon**
Drugs, Doctors and Government
Harry F. Dowling, MD, Chicago

Wednesday Afternoon, September 25

Two Postgraduate Courses (Continued from morning session)
(See pages 918 and 919 for subjects and speakers)

2:00- 5:00 p.m. **Trauma: General Session**
Sponsored by Section on Surgery

Moderator: Paul W. Gikas, MD, Veterans Administration Hospital, Ann Arbor

Title to be selected
J. Cuthbert Owens, MD, University of Colorado Medical Center

The Extrication of Injured Personnel from Wrecked Vehicles
Colonel Louis C. Kossuth, MC, USAF, ENT Air Force Base, Colorado

4:00- 5:00 p.m. Trauma (Second Meeting)
Moderator: Robert F. Wilson, MD, Wayne State University

Title to be selected
Murray L. Thomas, MD, Wayne State University

Title to be selected
Harvey Y. Lewis, MD, Wayne State University

The Trauma Section to meet after the Session.

2:00- 3:15 p.m. **Pediatric Problems: General Session**

2:00 p.m. Management of Respiratory Failure in the Newborn
Leo Stern, MD, McGill University Faculty of Medicine, Montreal

2:40 p.m. Diagnosis and Management of Infections in the Newborn
Joseph V. Baublis, MD, University of Michigan

4:00- 5:00 p.m. **Relief of Pain: General Session**

Sponsored by Section on Anesthesiology and Michigan Society of Anesthesiologists

Moderator: Shirley Austin, MD, Detroit

Title to be selected
John W. Ditzler, MD, Chicago Wesley Memorial Hospital

5:00- 6:00 p.m. **Fireside Discussions**

Speaker Discussants:

Paul W. Gikas, MD, Ann Arbor
Jerome A. Gold, MD, Woman's Medical College of Pennsylvania
Kaye H. Kilburn, MD, Duke University
Louis C. Kossuth, Colonel, USAF, MC
Gordon L. Snider, MD, Boston University

Wednesday Section Programs and Business Meeting

(Sections are listed in alphabetical order)

4:00 p.m. **Section on Allergy and Applied Immunology**

Mechanisms of Immunologic Tissue Injury
David Hawkins, MD, California

10:45- 2:00 p.m. **Section on Dermatology**

Meeting and Luncheon

Panel: Oral Mucous Membrance Lesions
Henry G. Bryan, MD, Wayne State University
Myron Kaufman, DDS, Detroit
Edward A. Krull, MD, Detroit
Amir H. Mehregan, MD, Wayne State University

6:00 p.m. **Section on General Practice**

Reception and Meeting
Program being completed

7:30- 8:45 a.m. **Section on Obstetrics and Gynecology**

(See Page 918 for Breakfast Roundtable Discussion)

4:00 p.m. **Section on Ophthalmology**

Meeting and Reception

Title to be selected
Robert J. McDonald, MD, Royal Oak

4:00- 9:00 p.m. **Section on Otolaryngology**

Tracheotomy and Nastrotracheal Intubation in Children
Herbert G. Birck, MD, Columbus

Reception and Dinner will follow program

4:00 p.m. **Section on Pediatrics**

Program being completed

4:00 p.m. **Section on Physicial Medicine**

Organizational Meeting

1968 Annual Session Program-Continued

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Wednesday, September 25 — Continued

Noon-2:00 p.m. **Section on Plastic Surgery**
Luncheon and Program
Surgery of the Parotid Gland
Robin Anderson, MD, Cleveland Clinic

2:00- 3:15 p.m. **Section on Public Health and Preventive Medicine**
Medicare and Medicaid — Their Impact:
—From the Viewpoint of the Medical Care Administrator
Avedis Donabedian, MD, University of Michigan
—From the Viewpoint of the Private Practitioner
Beverly C. Payne, MD, University of Michigan

5:00 p.m. **Section on Radiology and the Detroit Roentgen Ray Society**
Reception, Dinner, Meeting
Lymphatic System
Manuel Viamonte, Jr., MD, University of Florida School of Medicine
Reception and Dinner

Thursday Morning, September 26

7:30- 8:45 a.m. **Breakfast Round Table Discussion**
Sponsored by Section on Urology and
Detroit Urological Society
Malignancies of the Genito-Urinary Tract
George T. Mellinger, MD, University of Minnesota
Willet F. Whitmore, MD, Cornell Medical College

7:30- 8:45 a.m. **Breakfast Round Table Discussion**
Sponsored by the Section on Proctology
Treatment of Recurrent Carcinoma of the Colon and Rectum
Edward L. Moorhead, MD, Grand Rapids

7:30- 8:45 a.m. **Breakfast Round Table Discussion**
Sponsored by Section on Anesthesiology and
Michigan Society of Anesthesiologists
Title to be selected
John W. Ditzler, MD, Chicago Wesley Memorial Hospital

8:45- 5:00 p.m. **Postgraduate Course on Blood Disease**
By advance registration only
Moderator: Arnold R. Axelrod, MD, Detroit

MORNING:

9:00 a.m. Orientation to Anemia
Julius Rutzky, MD, Wayne State University

11:00 a.m. An Approach to Hemolytic Anemias
Scott N. Swisher, MD, Michigan State University

AFTERNOON:

2:15 p.m. The Leukocytes — Differential Patterns and Relation to Leukemia
George Clifford, MD, Sloan Kettering Institute, NYC

4:00 p.m. An Orientation to Platelet Diseases
Arnold R. Axelrod, MD, Wayne State University

8:45- 5:00 p.m. **Postgraduate Course on Difficult Decisions in Digestive Diseases**
By advance registration only

Moderator:

Guest Expert: J. Edward Berk, MD, California College of Medicine
Guest Expert: Alfred S. Frosbese, MD, Abington Memorial Hospital
Abington, Pa.

Guest Expert: Melvin A. Block, MD, Ford Hospital, Detroit

Special Contributors:

An Esophageal Problem
Joseph A. Rinald, Jr., MD, Detroit

A Perplexing Gastric Lesion
Bernard M. Schuman, MD, Ford Hospital, Detroit

A Peptic Ulcer Problem
William F. O'Driscoll, MD, Grand Rapids

An Ileo-colitis Problem
Eugene A. Gelzayd, MD, Southfield

A Pancreas Problem
Ramon R. Joseph, MD, Eloise

A Liver Problem
Keith S. Henley, MD, University of Michigan

9:00-Noon **Cardiovascular Diseases: General Session**

Sponsored by the Section on Internal Medicine
Program Chairman: Richard J. Bing, MD, Wayne State University

9:00- 9:30 a.m. Pulmonary Embolus
Park W. Willis, III, MD, University of Michigan

9:30-10:00 a.m. Pediatric Cardiology
Charlotte Ferenz, MD, Buffalo, N.Y.

10:00-10:30 a.m. The Effect of Nicotine and Alcohol on the Heart
Richard J. Bing, MD, Wayne State University

10:30-11:00 a.m. Cardioversion
Robert England, MD, Peter Bent Brigham Hospital, Boston

1968 Annual Session Program-Continued

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Thursday, September 26 — Continued

11:00-Noon Round Table Discussion on Coronary Artery Disease — Its Mechanisma and Treatment

Topics to be included: The Coronary Care Unit and Its Use; The Treatment of Acardiogenic Shock, The Prevention of Coronary Artery Disease and Epidemiology of Coronary Artery Disease

Discussants:

Moderator: Richard J. Bing, MD, Wayne State University
Erwin Robin, MD, Wayne State University
Raymond S. Kurtzman, MD, Wayne State University
Raymond E. Fuller, MD, Grand Rapids
Jack M. Kaufman, MD, Wayne State University
Leon D. Ostrander, MD, University of Michigan
Agustin Arbulu, MD, Wayne State University

9:00-10:00 a.m. **Prostate Carcinoma: General Session**

Moderator: Edward J. Shumaker, MD, Wayne State University

Title to be selected
George T. Mellinger, MD, University of Minnesota

Title to be selected
Willet F. Whitmore, Jr., MD, Cornell Medical College

10:45-Noon **Calcium—Too Much, Too Little: General Session**
Moderator: Richard W. Smith, MD, Ford Hospital, Detroit

Panel Discussion by:

Louis V. Avioli, MD, Washington University School of Medicine
Robert D. Johnson, MD, University of Michigan
Boy Frame, MD, Ford Hospital, Detroit

Noon- 2:00 p.m. **General Luncheon**

Organ Transplantations
David Hume, MD, Medical College of Virginia

Thursday Afternoon, September 26

Two Postgraduate Courses (continued from morning session)
(See pages 922 and 923 for subjects and speakers)

2:00- 5:00 p.m. **General Session:**

What's New in the Practice of:
Moderator: Alexander J. Walt, MD, Wayne State University

Cardiovascular Diseases
Richard J. Bing, MD, Wayne State University

Cancer
Michael J. Brennan, MD, Wayne State University

Transplantation
David Hume, MD, Medical College of Virginia

Urology
George T. Mellinger, MD, University of Minnesota
Willet F. Whitmore, Jr., MD, Cornell Medical College

Gynecology
Samuel J. Behrman, MD, University of Michigan

G-I Tract Diseases
J. Edward Berk, MD, California College of Medicine

Infections and Antibiotics
A Martin Lerner, MD, Wayne State University

Pediatrics
Charles F. Whitten, MD, Wayne State University

Endocrine Diseases
Raymond C. Mellinger, MD, Ford Hospital, Detroit

2:00- 3:15 p.m. **Diabetes: General Session**
Cosponsored by Michigan Diabetes Association
Moderator: Fred W. Whitehouse, MD, Ford Hospital, Detroit

2:00- 2:45 p.m. Pathophysiology of Acute Metabolic States in Diabetes
Buris Boshell, MD, Medical College of Alabama

2:45- 3:15 p.m. Panel discussion on Diabetic Coma and the Diabetic in Coma
Buris Boshell, MD, Medical College of Alabama
Laurence H. Power, MD, Wayne State University
John B. Bryan, MD, Royal Oak
Richard D. Hohl, MD, Ford Hospital, Detroit

4:00- 5:00 p.m. **Psychiatric Problems of the Aging Population: General Session**
Moderator: Laurence Koltonow, MD, Southfield

Title to be selected
Henry W. Brosin, MD, University of Pittsburgh School of Medicine

Discussants:
Now being selected

Thursday Meetings of Sections and Related Groups
(Sections are listed in alphabetical order)

11:00 a.m. **Section on Internal Medicine**

Business Meeting following General Session on Cardiovascular Diseases

10:00-Noon **Section on Neurological Surgery and Michigan Society of Neurological Surgeons**

Reception-Dinner

Section on Occupational Medicine

Capacitance Respirometry — A New Method of Measuring Lung Impairment
Robert Barrow, PhD, Wayne State University

1968 Annual Session Program-Continued

ALL EVENTS AT SHERATON-CADILLAC, DETROIT, UNLESS OTHERWISE STATED

Thursday, September 26 — Continued

4:00 p.m. **Section on Orthopedic Surgery and Michigan Orthopaedic Society**

Program-Reception-Dinner:

Studies on Trunk Growth in Normal Children and in Children with Growth Disorders
I. V. Ponseti, MD, University of Iowa

9:30- 9:00 p.m. **Section on Pathology and Michigan Society of Pathologists**

Morning: Business Meeting

Luncheon and possible address

Slide Seminar on Diseases of Skeletal Muscle
William K. Engel, MD, National Institutes of Health

Reception and Past Presidents' Dinner

6:00 p.m. **Section on Psychiatry and Neurology and Michigan Society of Psychiatry and Neurology**

Reception-Dinner-Meeting:

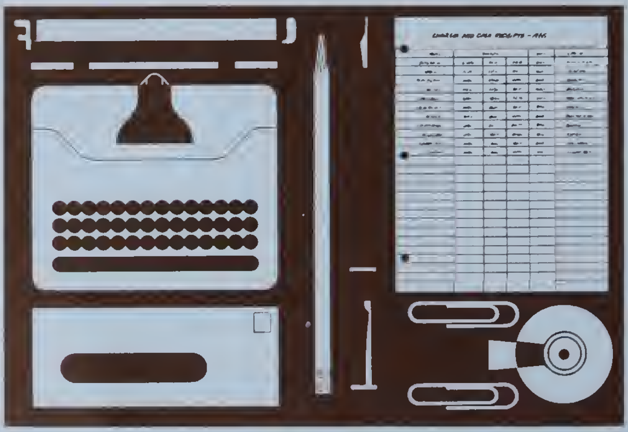
American Medicine and the Development of an American Style of Psychiatry
John C. Burnham, MD, Ohio State University

Discussants:
Allen J. Enelow, MD, Michigan State University
Laurence Koltenow, MD, Southfield

2:00 p.m. **Section on Thoracic Surgery**

Business Meeting

A Practical Approach to Carcinoma of the Lung
Hyman A. Brewer, II, MD, Los Angeles



An office Management Seminar will be offered for new physicians, residents, interns and senior medical students, Thursday, September 26 from 3 to 5:30 p.m., at the Sheraton-Cadillac Hotel.

Norman Henderson, M.D., East Lansing, is chairman for the MSMS committee planning this event.

A grant from Merck Sharp and Dohme makes this new Annual Session feature possible.

ADD: IN MEMORIAM

In addition to the names reported in the July "In Memoriam," the following news has reached the MSMS office. Details will follow in the August *Michigan Medicine*:

Francis J. Fitzpatrick, M.D., Pontiac, died May 22.

James M. Gaffney, M.D., Detroit, died March 17.

Walter E. McGillicuddy, M.D., Dearborn, died April 5.

Fred T. Reid, M.D., Troy, died June 12.

Nathan J. Reisman, M.D., Detroit, died June 14.

Maynard Southworth, M.D., Kalamazoo, died June 10.

Hugh A. Sullivan, M.D., Detroit, died June 1.

Gordon C. Tornberg, M.D., Cadillac, died May 26.

U-M Reunion Set Oct. 11-12

The Medical Center Alumni Society will hold its 1968 reunion at the University of Michigan, October 11-12.

Special guests will be the 50-year graduates from the 1918 medical and nursing classes. Other alumni especially invited are those whose graduating year ends with a 3 or 8, since the year 1918. For example: class of 1923, '28, 33, etc.

Presiding over the Annual Meeting in the North Campus Commons at noon, October 11 will be John O. Goodsell, M.D., Saginaw, president. Speakers on the program are Robben Fleming, President of U of M; William N. Hubbard, Jr., M.D., Dean of the Medical School; and Rhoda R. Russell, R.N., Dean of the Nursing School. The annual meeting will close with special ceremonies to induct the Class of 1918 into the Emeritus Club.

Lieberthal Selected President Upper Peninsula Medical Society

Paul Lieberthal, M.D., Ironwood, is the new president of the Upper Peninsula Medical Society elected during its recent annual meeting in Pembine, Wisconsin. Outgoing president is William S. Jones, M.D., of Menominee.

Continuing as secretary-treasurer is L. Grant Glickman, M.D., also of Menominee.

Bradley M. Harris, M.D., MSMS president from Ypsilanti, and George W. Slagle, M.D., MSMS delegate to the American Medical Association from Battle Creek, were among the featured speakers at the meeting.

Plans were made for the next annual meeting in Ironwood on the third weekend in June of 1969.

Cohen Investigates MD Medicare Fees

FROM AMA NEWS SERVICE

Health, Education and Welfare Secretary Wilbur Cohen estimated that the Medicaid program may cost the federal government between $2.5 and $3 billion in the fiscal year 1971.

The estimate for the next fiscal year (1968) is $2.1 billion. The original estimate for the current year was $1.7 but that proved substantially low.

Cohen told a House appropriations subcommittee that HEW was very much concerned and was making an intensive investigation of reported abuses by some physicians in federal medical programs.

OFFER BOOKLET RE MSMS STAND

MSMS members interested in obtaining a copy of "Where Does MSMS Stand?" are invited to write to Hugh W. Brenneman, Executive Director, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Chapters from the booklet are being printed each month in the *Michigan Medicine* journal.

FERGUSON CHOSEN APS PRES-ELECT

James Ferguson, M.D., Grand Rapids, has been selected to head the American Protologic Society.

Dr. Ferguson, who has served four years as secretary of the society, was named president-elect at the annual meeting in Denver. He will become president in June 1969.

MMS, PRESCAD SIGN DRUG PACT

Michigan Blue Shield and the Wayne County Health Department have contracted to furnish the first private sector drug vending and financing in the nation under Title V of the 1965 Social Security Amendments.

The drug contract provides that children of low income families may take "PRESCAD" prescriptions to any licensed pharmacy, which will in turn bill Blue Shield for the service.

PRESCAD — the name comes from the first letters of the classes of those eligible for the program, PREschool, SChool and ADolescent Children — is the Detroit-area program to furnish comprehensive and continuing health care in low income areas, apart from Medicaid. It exists under various names in 57 cities.

(From National Association of Blue Shield Plans newsletter, Vol. 4, No. 6.)

A Dead C + Scroll

BY INIS L. CLAUDE, JR.
ANN ARBOR

Verily, brethren, I say unto thee, he that putteth in no input, the same receiveth no output.

The prophet, Tubal, rose up and spake: "He that eateth and drinketh until midnight, and fighteth and carouseth until daybreak, yea, verily, there shall be no sleep for him that night.

"He that suppeth with psychologists, and breaketh bread with economists, and drinketh with sociologists, the same shall promote interdisciplinary cross-sterilization."

Ibid begat op cit, and op cit begat loc cit. Loc cit begat ipse dixit. So be it.

Thus saith the prophet, Ibid: "Yea, verily, he that procrastinateth, the same shall be late. And there shall be weeping and g-nashing of teeth.

"He that publisheth not, the same perisheth. He that citeth another in friendly footnote, the same shall be quoted in turn. To him that writeth a critical review, it shall be said, 'Judge not, that ye be not judged.' He that researcheth unceasingly shall gain everlasting tenure, and all the fringe benefits appertaining thereunto.

"Behold! He that cocktaileth and highballeth, dwelleth in the spirits. Let every man look to his own spiritous life.

"Blessed is he that surveyeth and computeth, for unto him shall be granted. Blessed is he that simulateth, for his conceptual framework shall cover a multitude of sins. But woe unto him who hath no model, who hypothesizeth not, and whose only rigor is mortis, for he shall be cast into outer darkness."

And now abideth teaching, service, and research. But the greatest of these is research.

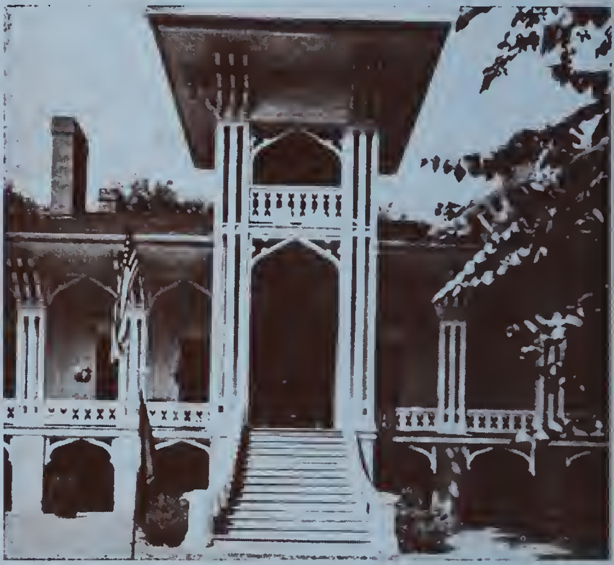
And Tubal declared to the assembled multitude, "He whose cup runneth over, the same should sip with care."

Thus spake the prophet Ibid: "Woe unto him that committeth not, for he shall be unpleasing in the sight of the Dean.

"Blessed be the name of the Ford. He that buildeth his center upon a foundation of Rockefeller shall endure, though the winds blow and the rains fall and beat upon that center. And manna from Carnegie will flow unto him, like the dews of Hermon that ran down upon Aaron's beard, even unto the hem of his garment. He shall dwell in a land of milk and money, and his research assistants shall rise up and call him Guggenheim. Blessed be the name of the Ford.

And the prophet cried out in the wilderness, saying: "Oh, ye Pharisees and Assistant Professors, ye men of short bibliographies and little faith, I declare unto thee — he that tooteth not his own horn, the same shall not be tooted." ☐

(Note: This article is reprinted with permission from the Michigan Daily and the Journal of Higher Education, and the author, who is associated with the University of Michigan Department of Political Science.)



KNOW MICHIGAN

Ever see this building?

The dream of bringing the spirit of Hawaii back to Marshall, Michigan, inspired Abner Pratt, a justice of the early Michigan Supreme Court and United States Consul to Hawaii in the 1850's, to have his "Honolulu House" constructed.

Justice Pratt loved the Hawaiian Islands, but had to return to Marshall because of the illness of his wife. The "Honolulu House" is a replica of his residence in Hawaii, and, until he died in 1864, Pratt re-duplicated his life in Hawaii by furnishing the house in a tropical decor, wearing tropical clothing, and serving the food he had eaten in Hawaii.

President Taft once spoke to a crowd of ten thousand from the veranda, and George Romney used the same spot to give an address in 1962. Presently the house is a historical museum under the direction of the Marshall Historical Society.

Photo by Allen Stross, Detroit.

MSMS CAMPAIGNS FOR PAP TEST

"If women do not become aware of the need for Pap tests, then 300 Michigan women and 14,000 in the nation will die in 1968."

That public warning has been issued by the MSMS Cancer Committee.

Because cervical cancer, in its early stages, is easy to detect and cure, the MSMS Cancer Committee is urging all Michigan women to get a yearly Pap test. The medical society committee is especially concerned because the majority of the 300 women who die every year in the state will leave small children motherless in the home.

"Only 18% of adult women living in Michigan have ever had such a test," reports Vainutis K. Vaitkevicius, M.D., Director for Clinical Cancer Services at Wayne State University and a member of the MSMS Committee.

AMA Offers Flier On Smoking-Health

As an additional cautionary reminder about the health effects of cigarette smoking, the AMA has published a new Timely Tip — "The Cigarette — A Dubious Companion."

"The Cigarette — A Dubious Companion" describes the effects of each puff of smoke as it enters the breathing passages and air sacs of the lungs and stresses that certain conditions and diseases are believed to be aggravated by cigarette smoking.

Some physicians include the AMA Timely Tips in their mailings and offer them in their reception rooms.

There are 100 Timely Tips to a set. Copies are available from the AMA Order Department at 20 cents each for 1-4 sets and 15 cents each for 5 or more sets.

MDPAC Breakfast Slated Sept. 25; Conyers to Talk

All MSMS members are invited to a special MDPAC Breakfast, Wednesday, September 25 in Detroit during the MSMS Annual Session.

Congressman John Conyers, Jr., of Detroit, will speak about the importance of citizenship participation in good government.

George Reno, M.D., Detroit, member of the MDPAC Board of Directors, is serving as chairman for the breakfast program.

MSMS members can read a progress report about MDPAC in the August issue of *Michigan Medicine.*

SERVES IN VIETNAM

Daniel D. Chapman, M.D., of Owosso, is currently serving in South Vietnam under the Volunteer Physicians for Vietnam program sponsored by the AMA.

Give $20,431 in AMA-ERF Checks to 3 Medical Schools

Checks for $20,431.63 were presented to the three Michigan medical colleges by MSMS officers in a ceremony June 5 at the MSMS headquarters.

The checks represented recent contributions by Michigan physicians and others for medical schools at the University of Michigan, Wayne State University and Michigan State University. The checks were from the AMA-ERF, which handles direct contributions to each of the 94 medical schools and also prorates general contributions by physicians and other interested individuals, companies and foundations.

The University of Michigan check was for $12,203.11; Wayne State University for $6,911.91, and Michigan State University for $1,317.61. The contributions were unrestricted and can be used by the medical schools for whatever purpose the school has greatest need.

Receiving the checks were Fred J. Hodges, M.D., for University of Michigan; Muir I. Clapper, M.D., Wayne; and Andrew D. Hunt, Jr., Dean of the College of Human Medicine, Michigan State University.

SPECIAL BEAUMONT COMMITTEE INSPECTS POPULAR MEMORIAL

Members of the MSMS Beaumont Memorial Committee toured the Beaumont attraction at Mackinac Island recently. They found again that the Memorial building and authenic exhibits are popular with thousands of Island visitors.

MSMS restored in 1954 the Astor retail store where Alexis St. Martin was wounded by a shotgun blast and was first treated by William Beaumont, M.D., the fort surgeon.

B. M. Harris, M.D., MSMS President, is chairman of the Beaumont Committee.

MSMS One Day Scientific Courses
September 25 & 26, Sheraton-Cadillac Hotel, Detroit

Enrollment Request:
Check course desired

Two courses to run simultaneously each day from 8:45 a.m. to 5:00 p.m. Registration is limited to the first 45 persons enrolling in each course. Course fee: $10 per course

Wednesday, September 25	(check one)	Thursday, September 26	(check one)
1. Infectious Diseases	______	1. Blood Diseases	______
2. Pulmonary Diseases	______	2. Difficult Decisions in Digestive Diseases	______

Name ______________________________

Address ______________________________

Check Enclosed ______________________________

Clip and Mail to MSMS, Box 152, East Lansing 48823

Course Content

Infectious Diseases

Chairman: A. Martin Lerner, MD

See Page 918 for Speakers, Subjects.

Recent advances in diagnosis, prevention, and therapy of bacterial and virus diseases will be discussed. Topics include respiratory virus, measles, and mumps vaccines; rubella; antiviral chemotherapy; interferon and new antibiotics with their special toxicities.

Pulmonary Diseases

Chairman: Geoffrey L. Brinkman, MD

See Page 918 for Speakers, Subjects.

The Pulmonary Course will cover management of respiratory failure, beginning with a discussion of the clinical manifestations and physiological abnormalities, and the best methods of care and rehabilitation. Speakers also will discuss pulmonary embolsis and advances in radiological techniques, medical therapy and surgical prevention and cure; and also acid-fast infections.

Blood Diseases

Chairman: Arnold R. Axelrod, MD

See Page 922 for Speakers, Subjects.

The postgraduate course in hematology is designed to orient the practicing physician to some of the common hematological problems manifested by changes in the peripheral blood cells. Our purpose is to develop an approach to the proper diagnosis and management of these entities.

Difficult Decisions in Digestive Diseases

Chairman: William S. Haubrich, MD

See Page 923 for Speakers, Subjects.

Practical problems encountered in gastroenterology, of concern to both the physician and the surgeon, will be explored by the case method. Each of six well-known MSMS members, active in the practice of gastroenterology, has selected and will present a case from their own files vividly illustrating particular problems in diagnosis and management. Doctors enrolled for the course will participate actively with invited guest experts in seeking answers to the questions raised. Controversy is expected, profitable discussion is assured.

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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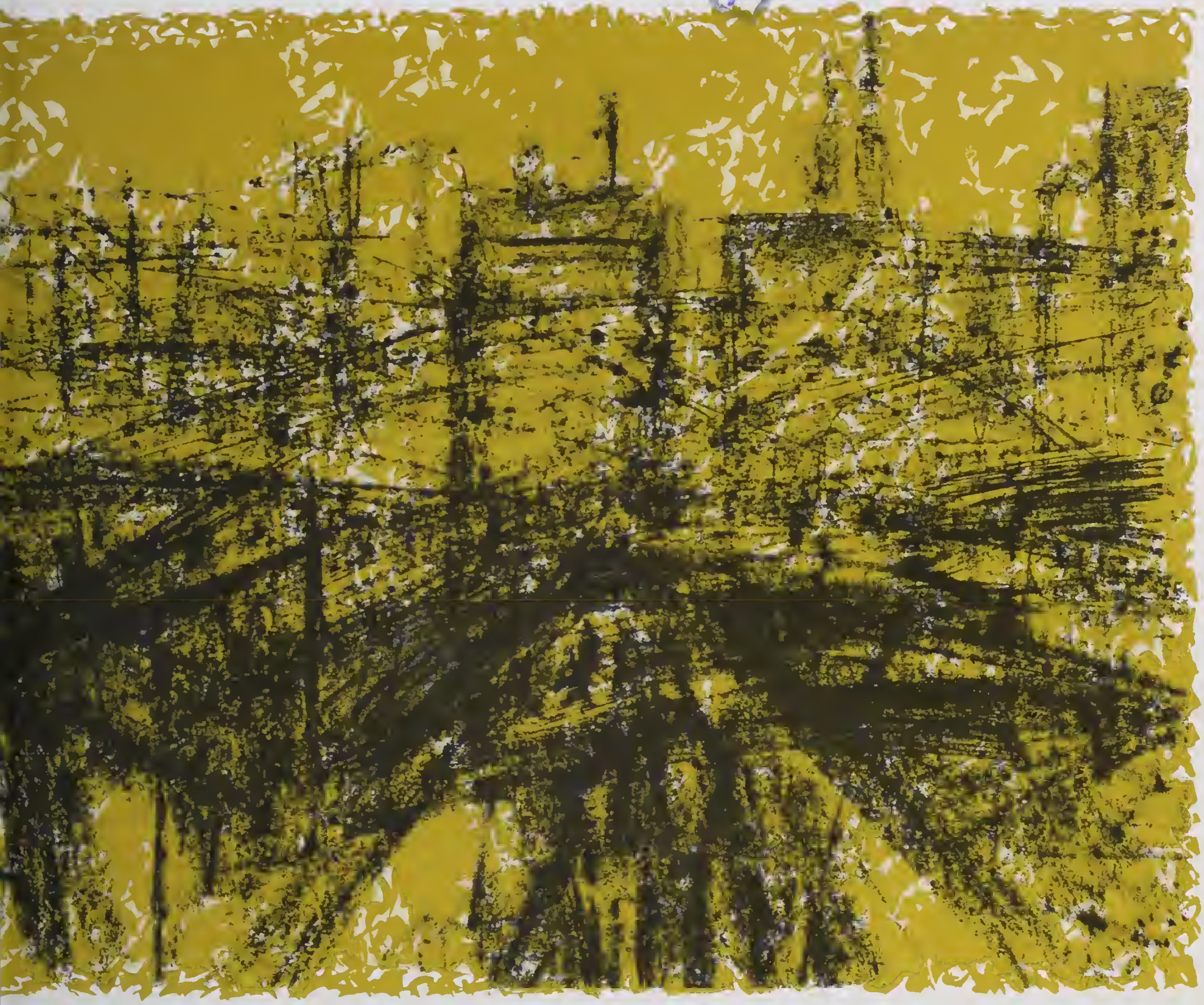
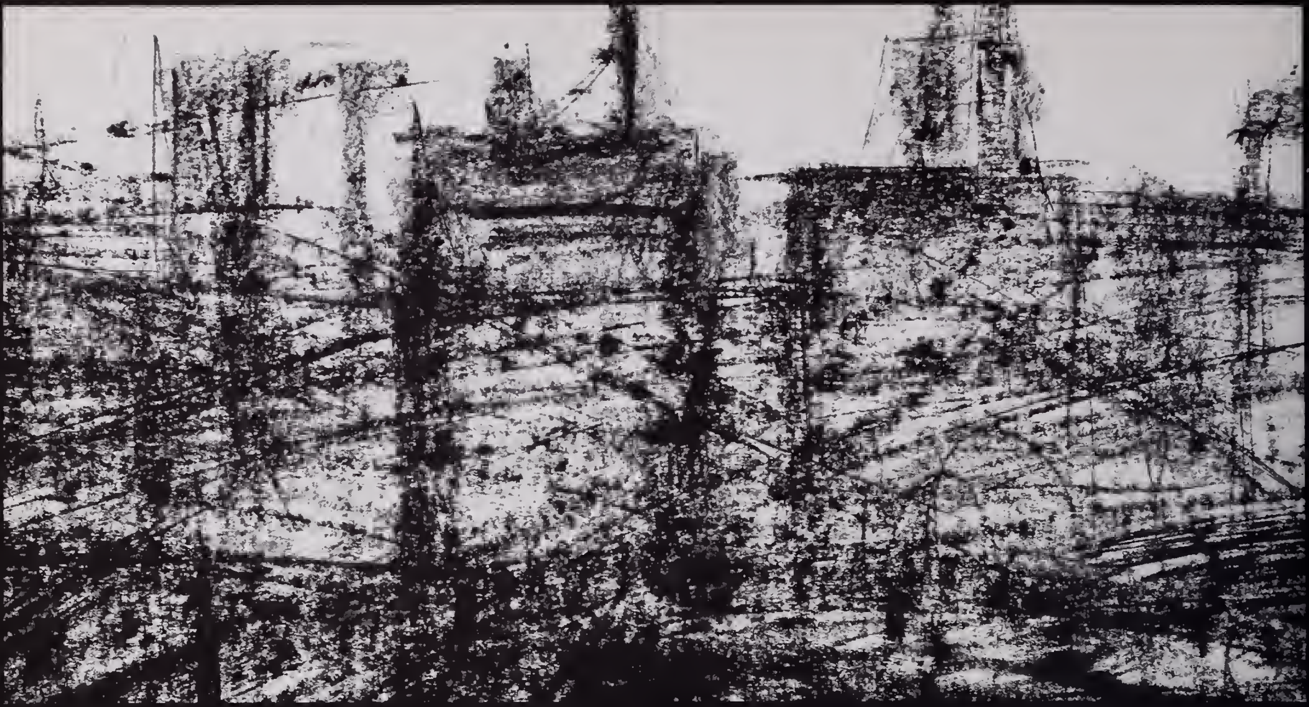


COME TO DETROIT, SEPT. 25-26, FOR MSMS ANNUAL SCIENTIFIC SESSION

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 15
AUGUST 1968

BLOCK OUT YOUR CALENDAR NOW:

Sept. 22-24 — MSMS House of Delegates
Sept. 25-26 — MSMS Annual Scientific Session
Sept. 24-26 — Woman's Auxiliary to MSMS
Sept. 25-26 — Michigan State Medical Assistants Society
Sept. 22-Oct. 20 — "Ars Medica Art Exhibit"



1968 MSMS ANNUAL SESSION SEPTEMBER 25-26 DETROIT

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Col. Louis C. Kossuth, MC, USAE, ENT, Air Force Base, Colorado

Relief of Pain
John W. Ditzler, MD, Chicago

Prostate Carcinoma
W. F. Whitmore, Jr., MD, Cornell Medical College

Organ Transplantation
David Hume, MD, Medical College of Virginia

What's New in G-I Tract Diseases
J. E. Berck, MD, California College of Medicine

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Henry W. Brosin, MD, University of Pittsburgh

Calcium — Too Much, Too Little
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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MICHIGAN MEDICINE

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961 Atypical Mycobacteria in the Detroit Area; Oscar Bigman, M.D., Morris F. White

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THE COVER

The art work on the cover is a charcoal sketch "Cityscape" by Mrs. Clara Rogers of Birmingham. It is being used in all the MSMS promotional efforts for the 1968 Annual Session to be held in Detroit, September 25-26. Mrs. Rogers works in many media and has had many works on exhibit in Detroit and other cities.

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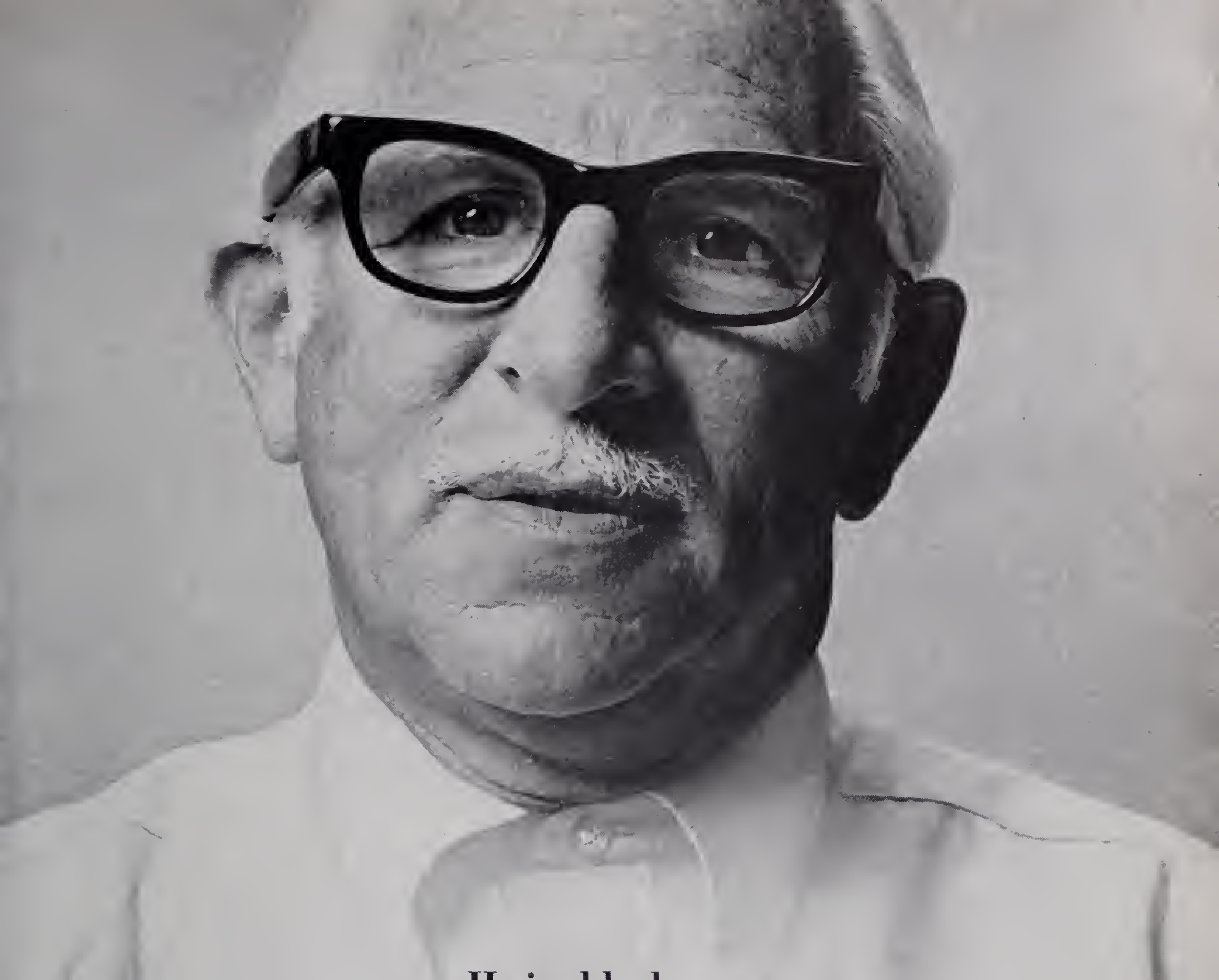

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ning: In renal impairment, usual doses may lead to excessive accumu-
on and liver toxicity. Under such conditions, lower than usual doses
indicated, and, if therapy is prolonged, serum level determinations
be advisable. A photodynamic reaction to natural or artificial sun-
t has been observed. Small amounts of drug and short exposure may
duce an exaggerated sunburn reaction which may range from ery-
na to severe skin manifestations. In a smaller proportion, photo-
rgic reactions have been reported. Patients should avoid direct
osure to sunlight and discontinue drug at the first evidence of skin
omfort. Necessary subsequent courses of treatment with tetracy-
es should be carefully observed.

cautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

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* Competitive Premiums as Shown Below

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100/300,000	$97.00	$170.00	$292.00	$389.00	$486.00	$33.00

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Class 5 — SURGEONS — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Write for complete information as to coverage and premiums.

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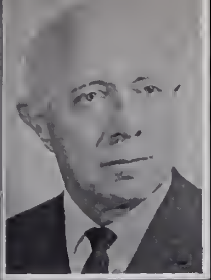

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Community Health Week Offers Three Targets

Most Americans today are living longer, healthier, more active and useful lives than in any period of our nation's history.

Many factors are contributing to our healthier lives such as the important achievements of modern medicine in the past few decades, community efforts in providing modern hospitals, public awareness of good health practices, and significant contributions to medical progress that are being made by medical scientists world-wide.

The purpose of Community Health Week (October 20-26) will be to focus public attention on the dramatic advances which have occurred in medicine and health care. The Annual Community Health Week project is proclaimed by the AMA and MSMS to encourage each of us to stimulate a greater public understanding of the growth, high quality and availability of health resources and facilities within the individual community.

In addition to an evaluation of our present assets, the 1968 Community Health Week this fall will focus attention upon (1) the growing problem of drug abuse, (2) the need to encourage and support the programs encompassing physical fitness, and (3) the expanding, urgent need for young men and women to train for medical and allied health careers. A career in medicine or any of its allied fields offers a challenging and rewarding future. You can help by encouraging capable young people to prepare for careers in health.

Each county society is urged to organize a health careers recruitment program. Doctors can speak to school assemblies, can consult with school counselors, can cooperate with the medical auxiliary and voluntary agencies, and can ask ahead for a visitation of the Michigan Health Council's health careers mobile.

As in other years, the Michigan Health Council and the Michigan Association of the Professions will jointly sponsor Community Health Week with MSMS.

All county medical societies are urged to develop appropriate programs marking the annual observance of Community Health Week, October 20-26 and to encourage other members of the community health team to join with them in planning and carrying out activities.

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Only 4.4% of patients taking Oracon discontinued it because of side effects

ORACON in a total conception-control program. Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

Mead Johnson also offers these important prerequisites for success in a conception-control program: information for the patient to help her understand conception control; and packaging to guide her in using the product correctly, according to your directions.

to guide you in prescribing ORACON

Indication: Oral contraception.

Effectiveness: Although some pregnancies have occurred while on therapy, oral contraception is the most effective method known.

Mechanism of Action: Gonadotropin suppression.

Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with Oracon has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of Oracon usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: Oracon is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on Oracon are available from Mead Johnson Laboratories.

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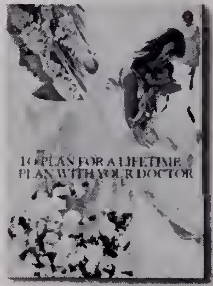
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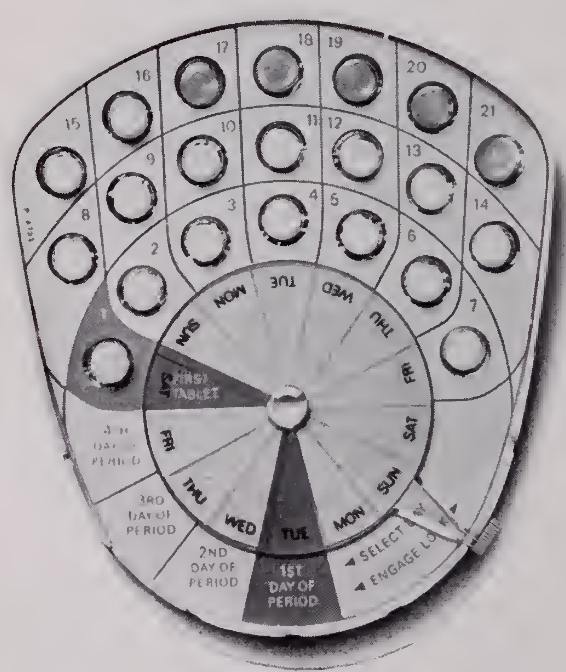

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Where Are We Heading?

BY J. H. AHRONHEIM, M.D.
JACKSON

(Note: This editorial first appeared in a recent issue of the Foote Hospital Pathological News Bulletin and is reprinted with permission of Doctor Ahronheim, who is also the editor. BLM)

According to recent reports in the press, the American Medical Association is considering steps designed to improve emergency care. This report does not exactly spell out what is meant by emergency care; it may be the attempt to relieve the pressure on hospital staff members in covering emergency service, or it may be to provide prompter service to those patients who are trying desperately and not too successfully to get a doctor's appointment, or it may be both.

Whichever it may be, the AMA is aware of a problem which is becoming increasingly more serious, and of which there is little hope in sight that it will improve. It is nationwide and is certainly felt more and more in our own community. An aging medical profession is losing more members by death and retirement than are being replaced by the slow influx of young men; the remaining practitioners are overworked and unable to take on more of a work load, physically and time-wise.

TO COMPLICATE THINGS even more, medicine is becoming more complex and there is greater demand for highly specialized diagnostic and therapeutic procedures than ever before. Medical practice is becoming a practice of specialties and the institution of family physician and general practitioner is slowly becoming a matter of the past. Today, we are no more satisfied with the patients' care which was considered standard 50 and even 25 years ago. To be rated a reasonably good physician, one must be certified by all sorts of professional bodies. Hospitals don't count anymore unless they are accredited by an increasing number of hospital organizations. Every person who has some connection with the practice of the healing arts needs now a license for whatever he is trained to do. Training and more training is emphasized. We are trying to make nurses out of aides, doctors out of nurses and university professors out of practitioners.

Obviously, all this is done to upgrade medical practice and has undoubtedly contributed to making American medical science the leader in the world. But it still does not take care of the one problem which is facing the entire nation: giving John Doe the care which he needs and when he needs it. Patients seeking a doctor's appointment often have to wait weeks before an available spot is found for them on the physician's schedule. The doctors do their utmost to meet the medical demands of the community, but there are still only 24 hours in a day, and coronary arteries can take only that much.

WHAT ARE WE GOING to do about this situation?

If there were a simple answer to this question, I am sure, it would have already been given by those who have studied the problem. Yet, let's think about it for a while and let's do a bit of speculating. Perhaps we might get some ideas from past experiences of our profession. Let us go back, for example, to the times, not too far removed, when a physician had his own little laboratory in the back of his office where he performed the simple tests which were known then, urinalysis, blood counts, occult blood determinations, and a few others which may or may not be obsolete today. When more tests were developed and laboratory medicine became more complex and sophisticated, the doctor needed a helper, an assistant, a technician. Usually it was his nurse or office girl whom he would teach the few tests which he was able to do. Later schools would be established for the purpose of turning out trained laboratory technicians. Thus, the fine profession of the medical technologist evolved.

Similarly, other phases of the practice of medicine, once the sole prerogative of the physician, would be delegated to specially trained personnel, and the professions of the physiotherapist, the dietitian, the anesthetist, and a few others were developed. They would work under the supervision of the physician and relieve him of many time consuming duties. I could well see that we carry this trend further yet. I could envision technicians for other phases of the practice of medicine by which a person would be trained solely for one specific phase, such as taking care of emergency cases, doing house calls for pediatric and obstetrical cases (there was nothing wrong with midwives who, in the past, had taken care of confinement cases most efficiently), making emergency

(Continued on Page 943)

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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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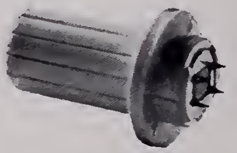

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decisions until the physician could take over. The physician, under whom these technicians would work, would be responsible for the technician's actions. The training would have to concentrate not only on making the student acquainted with his duties but, perhaps even more so, on making him aware of his limitations.

YOU MAY SAY that there are serious objections to this sort of medical practice by technicians. You may argue that the patient who calls a doctor, wants to be seen by a doctor and not by a technician. But let us ask the same patient if he would rather suffer for hours until the doctor finally shows up or would settle on a specially trained person who would give him the desired relief until the doctor can take over. You may say that this type of practice violates the law pertaining to the practice of medicine. Maybe so, but, if need be, laws can be changed and this type of nonphysician assistant could develop into a well recognized profession sanctioned by law. You may argue that technician practice may impair the quality of the practice of medicine.

As long as the technician works under the doctor's strictest supervision, this is a very remote possibility, in fact, it may even improve medical practice, just as the profession of the medical technologist has improved medicine.

Whatever our objections may be, we have to face facts and have to compromise somewhere and sometime. If we don't, the medical profession will some day consist of long-haired super-scientists whose minds are perpetually in the clouds while the patients suffer from the common cold and perforated appendices.

LET'S FACE IT, the public is already getting mighty impatient with us. When a patient is miserable, he is not concerned about a doctor's tight schedule, or the rest which he didn't get last night, or the coronaries which threaten to close up on him. He wants relief and he wants it now.

Probably, things are not quite as critical as that yet, but the day will come when we have to make decisions if we want to live up to the principles to which we pledged ourselves when we recited the oath of Hippocrates. □

At Your Service

BY BROOKER L. MASTERS, M.D.
CHAIRMAN PUBLICATION COMMITTEE

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Why not get the habit of reading *Michigan Medicine* regularly to win your struggle for more time? The articles are crisply written, tightly edited, neatly arranged on the pages, and then printed and mailed as quickly as possible.

At your service.

Paradox of the Medical World

BY JOHN H. VAN DE LEUV, M.D.
OXFORD, MICHIGAN

(Note: This article is reprinted with the permission of the author and the Oakland County Medical Society Bulletin, which carried this item in a recent issue. BLM)

Physicians, in their practice, often deal with urgent if not emergent problems. Immediate decisions and fast action are indicated. On the whole, we do very well in this aspect of our professional lives.

We are, with the exception, perhaps, of professional writers, the most prolific penpushers in the world. We as a group talk more than any other profession apart from politicians and, possibly lawyers.

UNFORTUNATELY, MOST OF the writing and talking is directed at our colleagues. By and large we, as individuals and groups, do very little to make our opinions known to "the public." We seem to want to hide in our shells when it comes to expressing our views in the regular news media. We seem to shun publicity except when it is forced upon us, when we are approached on a specific topic. We tend to hide behind our code of ethics as if it were a bombastic barrier between us and the non-initiated.

Why is it that we do not write more letters to editors, to our representatives? Why don't we publish more articles in the "lay" papers? Why don't we circulate any petitions? With the possible exception of the TV programs, we, probably, have the largest audience in the USA. If every physician — or, let us say, half of the physicians in the USA — convinced three patients per day of our stand on certain important social, political or economical questions, we would reach about half a million persons daily, that is almost all of the population in the United States in less than a year!

ARE WE TOO BUSY to let ourselves be known? Don't we have the medical societies to take care of this aspect? Can we be bothered by these nonmedical issues? Who would listen to us anyway; haven't we lost most of our prestige in society in the last few decades?

The answers are that the medical societies can never take the place of personally expressed opinions. People are getting tired of hearing the AMA declare its stand — that doctor's UNION is only after more money for the medical profession anyway! But they may sit up and pay attention to an expression of opinion of their "own doctor." Are we too busy? One would think not, when we can spend part of an evening in a meaningless hospital staff meeting, when we can find time to serve on two, three or more committees. Why should we be bothered by these non-medical issues? Because we are first of all citizens and, as such, have to make sure that our society is in tip-top shape (meaning society in the broadest sense possible).

COULD IT BE THAT we are after our own welfare alone and the rest of the populace be damned? This seems to be the attitude that we assume in the eyes of many. And justifiably so.

What then can we do? For a starter, we can get more involved in local, political and educational matters. We can let our representatives know what we think about pending legislation, not as a group but individually. We can urge more action on pressing problems and keep harping on these. It would not hurt to publicize the fact that we work three to five months each year for our good Uncle Sam, before we start paying our nurse's wages and the rest of our overhead, that we spend hours and hours in meetings that have the welfare of the community, directly or indirectly at heart.

But, for Heaven's sake, let people, your patients, hear from us! ☐

HUBBARD DISCUSSES PATIENT'S RIGHT TO DIE

The right of a patient to die may, in some cases, supersede the right of a physician to attempt to further his life by operations such as heart transplants, said William N. Hubbard, M.D., dean of the University of Michigan Medical School, in a recent address to the graduating class at the Albany Medical College of Union University in New York.

"To sacrifice human dignity at the time of death or to make the process of dying a burden upon the living is not in the highest tradition of medicine nor is it justified in the humanist traditions," said Doctor Hubbard.

"The humane physician must learn to understand and accept death as an inevitable part of living. He must beware of treating his own anxiety that death represents his personal failure by unrestrained use of life-support systems," the medical dean continued. ☐

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Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

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Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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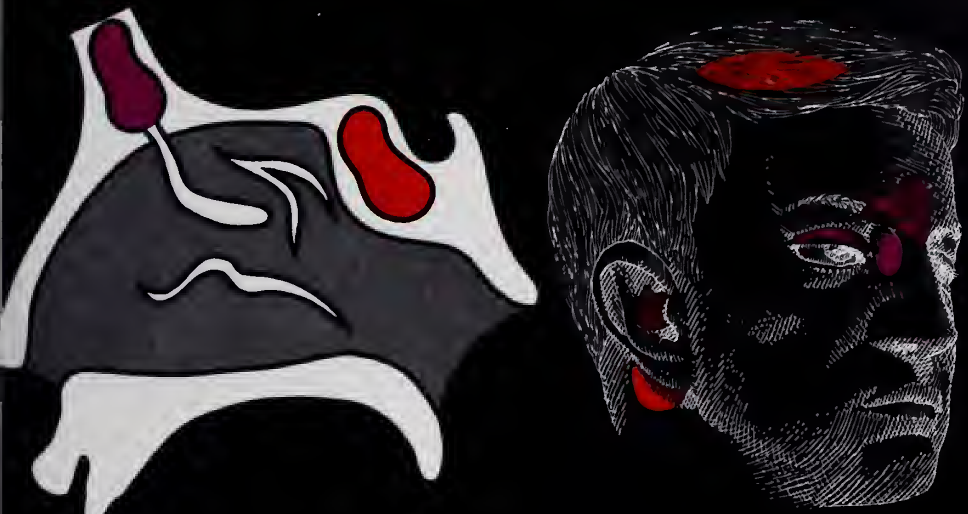
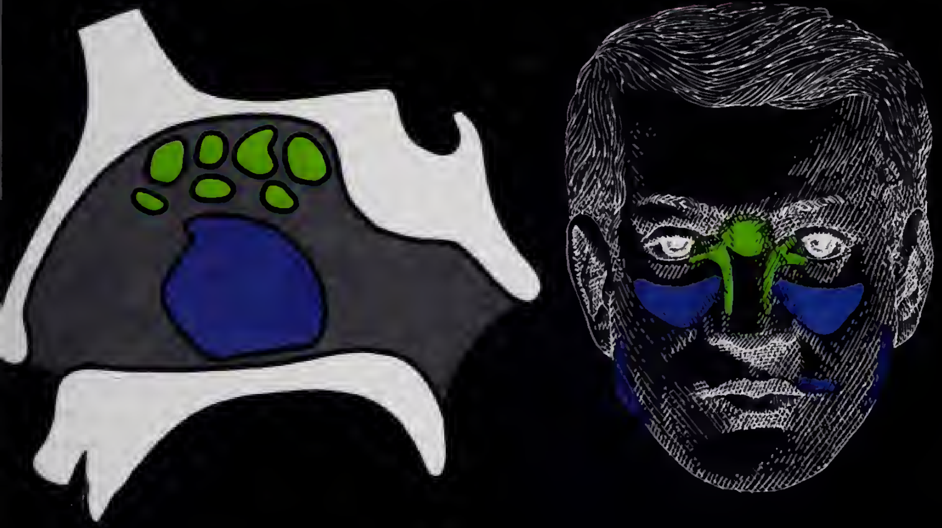
Sources of sinus headache



REGION OF SENSATION

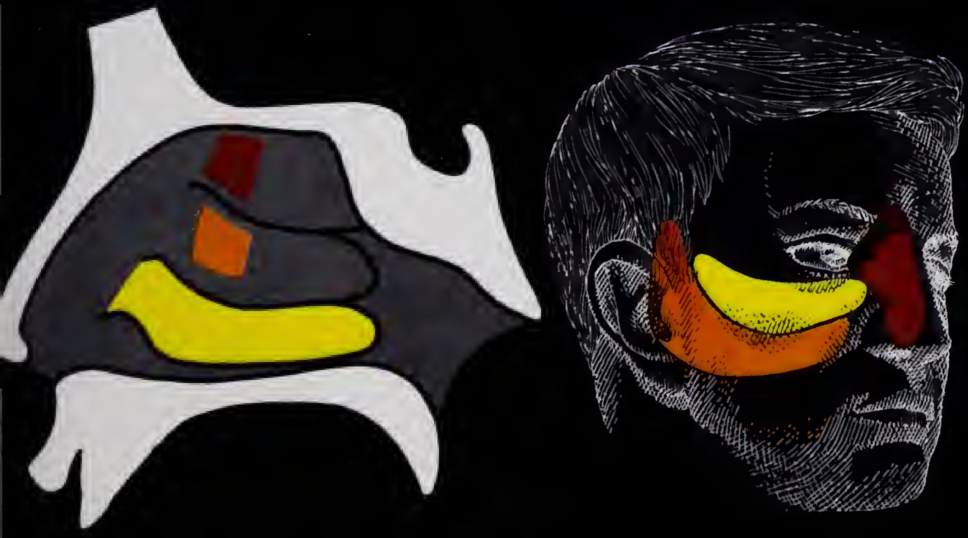
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



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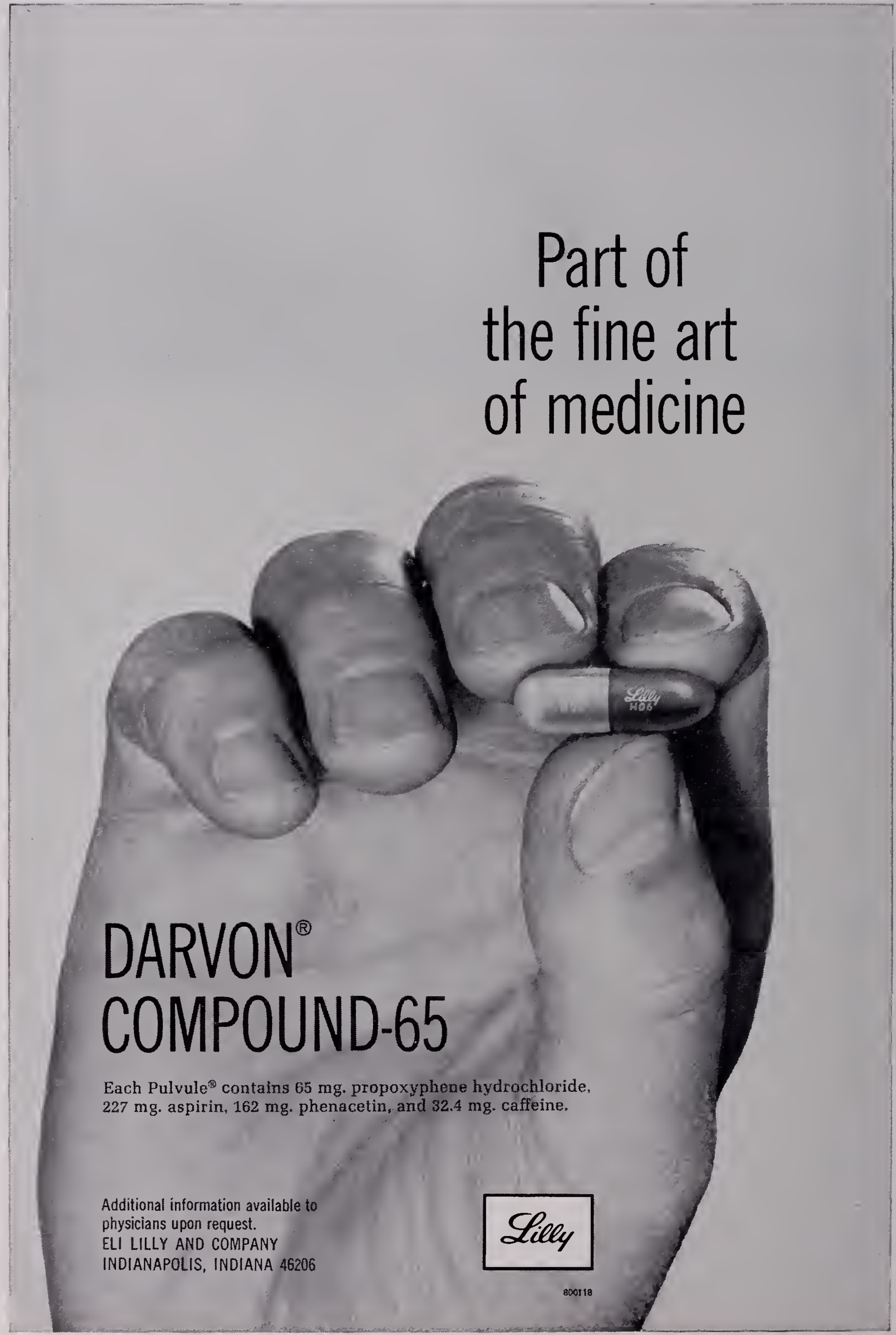
The May issue of *Michigan Medicine* featured a photograph of Lake Michigan on the cover in a salute to the annual Michigan Week observance.

The cover drew a letter from William S. Smith, M.D., head of the section of orthopaedic surgery at the University Hospital, Ann Arbor. He wrote:

"The attractive cover on the May, 1968 issue of the Michigan State Medical Society Journal is indeed a pleasant departure from the conventional "throw-away" look.

"There are so many beautiful scenes of Michigan available, that the journal should consider a different one for every cover." ☐



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Rupture of Pregnant Uterus

ABSTRACT: The article is a summary of a 10-year survey of ruptured uteri compared with an earlier article covering the previous sixteen years. The incidence in the latter is higher than in the former. Reasons for the increased incidence are noted. The fetal mortality in the present series is lower and maternal mortality was nil. A plea is made for awareness of diagnostic possibility and need for immediate action.

HELEN S. YAP CHAI, M.D.
FRED F. BIRKAM, M.D.
J. WALTON PICHETTE, M.D.
EDWARD A. DOUGHERTY, M.D.

Rupture of the pregnant uterus remains one of the most dangerous of the life-threatening accidents during the childbearing age.

It is an even greater menace to the unborn infant. According to Eastman and Hellman,[8] this condition produces more than half of the maternal deaths in uterine hemorrhage and is responsible for approximately 5% of maternal deaths. Garnet[10] states that 68% of the perinatal mortality in the United States associated with uterine hemorrhage is caused by rupture of the pregnant uterus. Any physician who practices obstetrics is exposed to this unanticipated and often unforeseen complication. The symptoms are frequently obscure, so that by the time the physician recognizes the condition, it is calamitous.

This challenging state, which can occur to any obstetrical patient at any time, demands the utmost in skills by the physician to decrease the extremely high maternal and fetal mortality rates.

This survey was prompted by the continuous hazard the ruptured pregnant uterus presents to the mother, fetus and the attending obstetrician. A 10-year review was documented and compared with the study of Birkam, Dougherty and Pichette,[3] published from this hospital, as well as studies of other authors.

There were 50,658 deliveries reported in the last decade in which there were 18 uterine ruptures. This incidence of 1:2814 is comparatively higher than the report of 1:4466 in the first 16 years of study of ruptured pregnant uterus in this hospital but compares favorably with the incidences reported by other writers (Table 1).

THERE WAS A LARGER number of traumatic ruptured uteri in our series; 20% higher than the previous study (Table 2). The etiology of these uterine ruptures in the present survey and the reasons for the increase were one or more of the following:

1. The increased use of cesarean section to solve obstetrical problems
2. Increased use of oxytocins
3. Poor obstetrical judgment.

Before discussing the frequency of this condition, we must define "ruptured uterus." According

TABLE 1 — INCIDENCE

AUTHOR	PERIOD	CASES	RATIO TO DELIVERY
Whitacre and Fang (China)	1922-1941	44	1:95
Paredes and Ismajovich (Paraguay)	1947-1957	27	1:515
McNides and McBurney	1923-1934	30	1:578
Delfs and Eastman	1920-1945	53	1:1010
Garnet	1958-1960	133 (114 hospital)	1:1034
Ferguson and Reid	1935-1955	84	1:1204
Bak and Heyden	1931-1953	52	1:1375
Voogd, Wood and Powell	1943-1955	12	1:1375
Pedowitz and Perell	1943-1954	87	1:1432
Ware, Jarrett and Reda	1932-1956	40	1:1508
Mathews, Raymond	1923-1959	111	1:1623
Waters, E.	1948-1960	50	1:2086
Ewing	1930-1956	37	1:2598
Salzmann	1950-1962	32	1:2665
Birkam, Dougherty and Pichette (MCMH)	1939-1955	17	1:4466
Yap Chai et al (MCMH)	1956-1965	18	1:2814

TABLE 2

ETIOLOGIC COMPARISON OF PRESENT AND PREVIOUS STUDIES

ETIOLOGY	1956-1965		1939-1955	
	Cases	Per Cent	Cases	Per Cent
— LCCS	2	11.1		
Cesarean		27.8	5	29.4
— Classical	3	16.7		
Previous surgery	2	11.1	1	5.9
Spontaneous	2	11.1	6	35.3
Traumatic	9	50.0	5	29.4
TOTAL	18	100.0	17	100.0

to Eastman,[8] it is a term to denote rupture only after the period of viability of the fetus, that is, 20 weeks or a fetus weighing 500 gm or more. The occult rupture or dehiscence is gradual in development and, as the name implies, is painless; whereas true ruptures are sudden in onset and almost always are associated with severe pain and shock. According to Kaltreider and Krone:[14] "Rupture is the separation of the entire uterine wall, with or without peritoneal involvement, associated with hemorrhage. Whereas dehiscence is not associated with hemorrhage and is often diagnosed at the time of elective surgery."

This study included only the cases with viable fetuses; our series ranges from 32-44 weeks with all occult ruptures.

Classification of the Causes of Ruptured Uterus

I. Rupture with previous scar
  A. C-Section
    1. Low transverse cervical C-Section — LCCS
    2. Classical C-Section
  B. Previous uterine surgery other than C-Section.

II. Rupture of Intact Uterus
  A. Spontaneous
    1. Associated abnormalities or diseases of the uterus
    2. Idiopathic
  B. Traumatic obstetrical procedures — forceps, breech extraction, version and extraction, pitocin or oxytocic induced labor, etc.

Case Review and Comments on Traumatic Ruptures

CASE 1. The patient was 24 years old, gravida III, para II, after 38 weeks of gestation in active labor with double footling presentation. Progress of labor was good for six hrs.; the cervix was 7-8 cm dilated when a prolapsed cord was noted. Breech extraction was performed under general ether anesthesia. A live girl weighing six pounds, 6 ounces was delivered. Examination of the uterus revealed a 3-4 cm laceration of the right lateral fornix and the right side of the cervix, extending about 7 cm into the fundus. A total abdominal hysterectomy was performed, and the patient received 1500 cc whole blood. Except for a low grade fever during the first four postoperative days, the postoperative course was uneventful. She was given Penicillin and Terramycin and was discharged on the 9th postoperative day.

Comment: There was proper management and diagnosis was established by immediate uterine exploration. The possibility of Duhrssen's incision might have been entertained.

CASE 2. The patient was 32 years old, gravida IX, para VII, and was seven months pregnant. Two weeks PTA, the patient had vaginal bleeding, weight gain, edema, elevated blood pressure and headache; fetal movements were absent. The patient went into spontaneous labor, after nine hours; a low forceps delivery was performed under spinal anesthesia. The head was delivered with ease, but when traction was made on the mascerated fetus, decapitation resulted. Evisceration was

The co-authors are all members of the staff of the Department of Obstetrics and Gynecology, Mt. Carmel Hospital, Detroit. Doctor Yap Chai is now in San Francisco.

attempted very carefully with a uterine dressing forceps, but failed. However, the trunk of the fetus was delivered by fundal pressure and a cervical laceration extending into the left broad ligament was felt on immediate exploration of the uterus. The patient had a subtotal abdominal hysterectomy. The blood pressure dropped to 60/30 during the procedure; otherwise, the postoperative course was uneventful. She received 1000 cc of whole blood.

Comment: Good postpartum management resulted since the diagnosis was established by immediate routine uterine exploration.

CASE 3. The patient was 30 years old, gravida VI, para V, at 39 weeks of gestation with a past history of orthopnea, ankle and pedal edema for four weeks. PTA. Her blood pressure was normal. Intravenous pitocin induction was given for three hours without commencement of labor. This was repeated 18 hours later, strong contractions started after 85 minutes. At this time a transverse presentation was noted with fast and irregular fetal heart tones. Pitocin was discontinued. Two hours later, contractions ceased and a slight drop in blood pressure to 90/64 was noted with severe abdominal tenderness and a slow fetal heartbeat. A Porro cesarean section was performed an hour later, and a six to seven inch rupture was found on the posterior aspect of the uterus. At laparotomy, a stillborn male fetus was found lying free in the abdominal cavity. The patient was in profound shock for 15-20 minutes. A cut-down was performed and Solu-Cortef and 2300 cc of whole blood were given intravenously. The postoperative course was uneventful.

Comment: The presentation of the fetus should have been accurately diagnosed prior to intravenous pitocin induction. Cesarean Section, if performed earlier, might have prevented the catastrophe to both the fetus and the mother.

CASE 4. The patient was 39 years old, gravida IV, para III, admitted at 41 weeks of gestation with false labor. Membrances ruptured spontaneously the following morning. A flat plate of the abdomen revealed a cephalic presentation. Quinine, gr X, was given; no contractions were noted. The following day, thick golden-brown amniotic fluid was seen, the patient was afebrile, intravenous pitocin induction was started. Contractions were every three minutes, lasting 35 seconds. After two hours, meconium stained fluid was noted. Vaginal examination showed questionable dilatation and undetermined presentation. Five and one-half hours after the intravenous pitocin was started, fetal heart tones ceased; the blood pressure was 90/50. Consultation was obtained and a subtotal hysterectomy with bilateral salpingo-oophorectomy was performed for rupture of the right posterolateral half of the uterus and cervix extending into the broad ligament, infundibulopelvic ligament and posterior parietal peritoneum. A dead male infant weighing seven pounds, nine ounces was found free in the abdominal cavity. The patient was in shock and received 2500 cc of whole blood.

Comment: If attention had been focused on the meconium stained fluid in a cephalic presentation with a near floating head plus irregular fetal heart tones, consultation would have been sought immediately and pitocin omitted.

CASE 5. The patient was 31 years old, gravida VI, para IV, abortus I, admitted at 39 weeks of gestation after spontaneous rupture of the membranes 1½ hours earlier. Quinine, gr X, was given and repeated four hours later. Eleven hours later she delivered, spontaneously a live boy weighing eight pounds, ten ounces. Immediately, the mother went into shock. Prompt exploration of the uterus revealed a long, deep laceration at the left lateral cervix extending into the lower uterine segment and uterus. Subtotal abdominal hysterectomy with right salpingo-oophorectomy was performed because of blood extravasated into the right infundibulopelvic ligament. She received 3000 cc of whole blood. The postoperative course was uneventful.

Comment: Diagnosis was established immediately upon routine uterine exploration.

CASE 6. The patient was 36 years old, gravida VI, para V, admitted at term in labor. Four and a half hours later, Pinard's maneuver was performed and a male infant weighing eight pounds, 13 ounces was delivered in good condition by breech extraction. Uterine exploration was performed with a negative result. About two hours later, a slight drop in blood pressure to 80/60 was noted, the pulse was 80 and regular; 1000 cc of 5% glucose in water was started. Four hours later, a mass the size of a football was palpated at the right adenxa. Supracervical hysterectomy with bilateral salpingo-oophorectomy was performed. A tear 5 cm long in the lower segment, extending into the right broad ligament with hematoma formation laterally and posteriorly to the right kidney was found. There was free blood in the peritoneum. The patient received 3500 cc of whole blood and 25 gm Mannitol and terramycin. She recovered uneventfully.

Comment: Importance of a thorough and careful uterine exploration is emphasized.

CASE 7. The patient was 33 years old, gravida VII, para VI, at 40 weeks in gestation with questionable labor and a transverse presentation, with the head to the right and the back inferior. External version was attempted and failed, but there was success on the second attempt with good fetal heart tones. A low forceps delivery under spinal anesthesia was performed after eight hours, followed by discovery of uterine rupture at the midportion of the lower uterine segment, extending into the fundus uteri approximately five inches. The tear curved somewhat to the left side and extended to within five cm of the tubouterine junction. Subtotal abdominal hysterectomy was performed with a right salpingo-oophorectomy; 1000 cc of whole blood was given. The postoperative course was uneventful.

Comment: Diagnosis again was rendered on routine uterine exploration. The advisability of external version may be controversial.

CASE 8. The patient was 39 years old, gravida IX, para VII, abortus I, after 40 weeks gestation and active labor for 11 hours. Breech extraction was executed with extraction of left nuchal arm under ether anesthesia. On routine uterine exploration, a posterior cervical laceration was found which extended into the right posterolateral side of the uterus with a hematoma in the right broad ligament. A supracervical hysterectomy with right salpingo-oophorectomy was performed. She was given 2500 cc of whole blood plus 4 cc of Levophed and calcium gluconate intravenously. The patient was in shock throughout the procedure. Her condition was fairly satisfactory until two hours later when moderate vaginal bleeding was noted and an exploration was made abdominally. A laceration 2 cm long was found at the right lateral aspect of the vagina and was repaired. The postoperative course was uneventful except for pulmonary congestion on the first day. She was discharged the 8th postoperative day with a hemoglobin of 9.9 gm.

Comment: Again, the diagnosis was obtained by immediate postpartum exploration of the uterus.

CASE 9. The patient was 44 years old, gravida XVII, para XV, abortus I, admitted after 40 weeks of gestation with contractions every three minutes and moderate vaginal bleeding; fetal heart tones were absent. A cytogram revealed no evidence of placenta praevia; ROT was station -3. Desultory labor for 14 hours was unimproved with intravenous pitocin. The uterus became tense; therefore, cesarean section was performed for primary uterine inertia and questionable marginal sinus rupture or abruptio placenta. A tear was found involving the whole thickness of the anterior myometrium, extending from the fundus to the bladder flap and hematomas were located in both adnexae. A stillborn male weighing eight pounds, fourteen ounces with intact membranes and pea soup thick amniotic fluid was seen. A subtotal hysterectomy with bilateral salpingo-oophorectomy was performed without blood transfusion. No complications were noted postoperatively.

Comment: Pitocin intravenously is contraindicated for a grand multipara and/or a floating head.

In the non-traumatic causes, the dictum "once a section always a section" still holds true, and this principle is followed by this department. An important example: a woman 25 years old gravida IV, para III, who had a cesarean section at her second delivery, for bleeding. She was allowed vaginal delivery with the third pregnancy. On the fourth admission, she was one week overdue and spontaneous delivery of a male infant weighing nine pounds, 13 ounces occurred in six hours. Immediate postpartum hemorrhage occurred. Exploration revealed rupture through the previous cesarean section scar. Subtotal hysterectomy was followed by uneventful recovery. She received 2500 cc whole blood for mild shock.

Maternal and Fetal Mortality Rates

In spite of the moderately higher incidence of uterine rupture in our series, it is gratifying to find a lower fetal mortality rate and the absence of maternal mortality in the present survey.

O'Driscoll and Quinn[14] pointed out that tear of a previous cesarean section scar may rank high in the list of causes of uterine rupture, but the maternal mortality rate is usually low (Table 3). In contrast, the maternal mortality rate in traumatic and spontaneous ruptures by comparison is high.

Factors Which Decreased Maternal and Fetal Mortality Rates

1. Early diagnosis — by immediate uterine exploration of all postpartum cases and especially those with previous uterine surgery, traumatic deliveries, pitocin induction, etc.
2. Early surgical intervention.
3. Adequate fluid, blood and drugs to combat shock.
4. Awareness of the dangers involved in traumatic obstetrical problems.
5. Use of antibiotics as indicated.
Diagnoses were rendered in both traumatic and non-traumatic cases:

a. In ten patients on routine uterine exploration with or without signs and symptoms of vaginal bleeding and/or shock. Of these, five presented with vaginal bleeding; seven were in shock.

b. One was diagnosed preoperatively as abruptio placenta, another as primary uterine inertia, and the third as impending uterine rupture.

c. Five were diagnosed because of palpable superficial parts and absence of fetal heart tones.

d. One was diagnosed at surgery.

These cases point out the importance of routine uterine exploration of all postpartum cases, especially following complicated deliveries, with or without external bleeding. The only exception, of course, is the case of gross intrauterine infections.

There were 7 fetal deaths and 11 live births among the 18 cases, which constitutes a 38.8% fetal mortality. However, one of the newborns died after 14 minutes in spite of resuscitation. Still, this figure is considerably lower than the average 68% fetal mortality rate in the United States. It is to be noted that the early diagnoses of ruptured uterus, good surgical technique and early institution of shock therapy, resulted in no maternal mortality and a considerable lowering of the fetal mortality rate.

Treatment consists of total abdominal hysterectomy with or without salpingo-oophorectomy in seven patients, subtotal hysterectomy in nine patients and two cesarean sections with repair of the ruptured area in two patients.

TABLE 3
MATERNAL MORTALITY IN UTERINE RUPTURES

		Post-Cesarean	Mortality		Non-Cesarean	Mortality	
AUTHORS	PERIOD	CASES	Number	Per Cent	CASES	Number	Per Cent
Delfs and Eastman[6]	1900-1944	10	2	20.0	43	23	53.5
Brierton[4]	1932-1946	46	1	3.8	31	18	58.1
Donnelly[7]	1931-1948	13	0	0.0	26	11	42.3
Beacham and Beacham[2]	1913-1950	23	6	26.1	73	40	54.8
Garnet[12]	1929-1952	6	1	16.7	15	11	73.3
Bak and Heyden[1]	1931-1953	13	0	0.0	37	8	21.6
Pedowitz and Perell[15]	1933-1954	34	1	2.9	41	9	22.0
Burkons[5]	1949-1954	35	1	2.9	30	6	22.0
Ferguson and Reid[9]	1935-1955	18	1	5.6	24	4	16.7
Ware, Jarrett and Reda[17]	1932-1956	16	0	0.0	55	10	18.2
Posner, Santos and Posner[16]	1949-1957	12	0	0.0	14	1	7.1
*Birkam, Dougherty and Pichette[3]	1939-1955	5	0	0.0	12	3	25.0
*Present Study	1956-1965	5	0	0.0	13	0	0.0
TOTAL (average per cent)		216	13	6.01	414	144	34.78

Summary

1. Eighteen cases of ruptured uterus occurring between 1956-1965 have been reviewed.

2. A comparison was made of the incidence of 1:2814 with that of other authors and our previous study.

3. Traumatic ruptures rank highest in the list, constituting 50% of all cases.

4. No maternal mortality was encountered.

5. Fetal mortality rate was 38.8%, lower than the average.

6. Treatment of ruptured uterus is presented.

7. A serious plea for routine exploration of the postpartum uterus is emphasized.

8. Traumatic ruptures can be avoided, in part, by more zeal and watchfulness on the part of the physician.

9. Early diagnosis decreases maternal mortality, morbidity and fetal mortality.

Editorial Note:

Obstetrics usually represents one specialty in which the end result usually leads to happiness on the part of all parties involved. Ruptured uterus is a catastrophe that is life-threatening to both mother and child and causes dismay in an otherwise happy situation. As the authors point out, the obstetrician should keep this possibility in mind and be ready for immediate intervention.

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Atypical Mycobacteria In the Detroit Area

ABSTRACT: The classification of the atypical mycobacteria is reviewed. Clinical disease in the Detroit area is most frequently due to Type III. Type II (Scotochromogens), almost always a non-pathogen, is the most common organism isolated.

BY OSCAR BIGMAN, M.D.
MORRIS F. WHITE
BOTH OF DETROIT

Although the atypical mycobacteria have been known for many years and the main identifying features classified by Runyon,[1] subclassification is still in process.[2, 3] Table I indicates the current but tentative classification. Organisms occasionally tall between the categories and are difficult to place specifically.

Organisms in the left hand column are considered pathogenic.

It was thought worthwhile to review the experience within the Detroit area to guide clinicians as to which organisms may be found in the vicinity and as to which ones may be difficult to treat.

A previous paper by R. A. Green[2] presents the only source of information previously available as to cases found in the State of Michigan. All the organisms were collected either in the Out-Patient Clinic or on the In-Patient Service at Herman Kiefer Hospital between Jan. 1 and Dec. 31, 1965. Out-patient records were not reviewed in detail since many of the sputa were submitted by patients under the care of private physicians and the clinical information available was inadequate.

A total of 479 out-patient sputa were positive for atypical organisms. There were 459 isolations of Group II, one of Group III, nineteen of Group IV. M. Kansasii (Group I) was never found.

Table II indicates the relative frequency with which M. tuberculosis and atypical mycobacteria were found. It will be noted that in the outpatient services atypicals were found more frequently than "typicals." Of course, most of these were Group II, non-pathogens.

Table III indicates the nature of the disease in patients whose sputa contained Type II-scotochromogens.

TABLE I — CLASSIFICATION

Runyon Group I	Photochromogens	
M. Kansasii		
Runyon Group II	Scotochromogens	
M. Scrotuloceum		tap water (aquae)
Runyon Group III	Nonchromogens	
Battey bacillus		M. Terrae
M. Avium		M. Gastri
M. Xenopei		
Runyon Group IV	Rapid growers	
		M. Fortuitum
		M. Phlei

TABLE II
SUMMARY OF ALL SPUTA SUBMITTED TO THE LABORATORY IN 1965

	Inpatient		Outpatient	
Negative for AFB	11,906	84.6%	11,958	91.1%
Positive for M. tuberculosis	2,007	14.3%	186	1.4%
Positive for atypical mycobacteria	102	0.7%	479	3.6%
Contaminated	51	0.4%	510	3.9%

Both authors are associated with the Herman Kiefer Hospital, Detroit.

TABLE III — IN-PATIENTS

Group II Scotochromogens only isolated		
benign non-progressive disease	isolated once 12 patients	more than once 2 patients
pneumonia clinically	isolated once 3 patients	more than once 1 patient
patient expired	isolated once 6 patients	more than once 1 patient
Group II **and** M. tuberculosis isolated	isolated once 16 patients	more than once 4 patients

Single isolates of Group II were obtained from three patients with bronchiectasis, one with pneumoconiosis, one with sarcoidosis.

The out-patient experience shows that there are many Group II Scotochromogens isolated in the Detroit area. Whether in the clinic with an insignificant lesion, or whether admitted with a more suspicious lesion, these Scotochromogens (aquae) are benign. Sometimes they appear coincidentally to a mycobacterium tuberculosis infection, in which situation they do not seem to alter the prognosis. They are probably contaminants derived from soil and water where they are commonly found. Occasionally cavitary disease is found. It is difficult at this time to know whether this represents a different strain (scrofula) or host resistance deficiencies.

The isolation of Group IV, rapid growers, M. Fortuitum or M. Phlei also seems clinically benign in our limited expreience.

On the other hand, the isolation of Group III, Battey bacillus, seems to carry a grave prognosis, our two patients showing inexorable progression to death.

These observations agree with the general consensus that Groups I and III are pathogenic and that the exact role of Groups II and IV are yet to be established. Further subdivision of Groups II and IV into laboratory distinct strains are needed.

CASE HISTORIES

1. (46054)

R. K., A 71-YEAR-OLD WOMAN was admitted on July 30, 1964 and expired on July 4, 1965. She had noted progressive dyspnea for 3 or 4 years, productive cough for 2 months, hemoptysis for 1 week. She had lost 20 lbs. in the previous year. She complained of night sweats for the previous 2 months.

TABLE IV

Group III	Battey	
	R.K.	Patient expired. The organism was isolated on eleven occasions.
	W.A.	Patient expired. The organism was isolated on ten occasions.
Group IV	M. Fortuitum	
	M.R.	Cystic disease of lung. Organism isolated once.
	F.H.	Recurrent migrating pneumonia. Organism isloated once.
	D.C.	Right middle lobe pneumonia. Organism isolated once.
	J.R.	"Classic" tuberculosis. M. Hominis isolated on five occasions. M. Fortuitum on one occasion.
	H.B.	Pneumonia in patient with carcinoma of the lung. M. Fortuitum isolated on one occasion.

In one patient, S.D., who clinically had silicotuberculosis, the organisms were apparently variable in cultural characteristics, being classified as I, twice; II, twice; and IV, three times.

Past History: Glaucoma for eleven years, treated with iridectomy, on the right. A daughter had had tuberculosis 15 years ago.

Physical Examination: Iridectomy, right eye. Lungs — moist rales at right base, soft apical systolic murmur. 1+ pedal edema.

Sputum cultures were always positive for mycobacteria Type III. X-rays showed slow progression. The patient became gradually more dyspneic and anemic. She was treated with isoniazid, streptomycin, P-amino-salicylic acid. Erythromycin added later, failed to alter the course of the disease.

2. (45356)

W. A., A 50-YEAR-OLD MAN was admitted on December 27, 1963 and expired on July 15, 1965. He had had bronchial asthma, non-seasonal, since the age of 18. Ten months prior to admission, he had developed a productive cough and weakness. He denied weight loss, fever and night sweats.

Past History: Heavy smoker and drinker. Occupation — janitor.

Physical Examination: Not remarkable except for absence of teeth, an increased A-P diameter of the chest and bronchial breath sounds in the left infraclavicular region.

Hospital Course: The patient was treated with streptomycin, isoniazid, P-amino-salicylic acid from 12/30/63 to 1/30/65. X-rays improved but the sputum remained positive for atypical mycobacteria. There was difficulty in classifying the organisms. On 4 occasions they were considered to be Group III and on 6 occasions, Group IV. In January, 1965, the combination of ethionamide, cycloserine and isoniazid were started. The X-rays began to show deterioration in the Spring of 1965. The patient expired quietly on July 15, 1965.

3. (43962)

S. D., A 75-YEAR-OLD MAN was admitted on October 12, 1965 for hemoptysis on two occasions. He had had a "cold" with cough and soreness of the left chest for about three weeks. Weight loss, fever and sweating were denied. Past history revealed that the patient had been a foundry worker for 27 years. He smoked 10 cigars a day. The main finding on physical examination was the presence of cavernous breath sounds in the left apex. On isoniazid, P-amino-salicylic acid, streptomycin and pyrizinamides, the cavity became smaller. The patient was discharged as "open negative" on May 27, 1965. Sputum was positive for atypical tubercle bacilli on seven occasions. The organisms were varibly identified as being of Group I, II and IV.

He was readmitted on March 12, 1967 for minor X-ray progression of his pulmonary disease. The intermediate PPD skin test produced an 11 mm. area of induration. Atypical mycobacteria were again isolated. The patient expired on May 24, 1967, following a transurethral resection, apparently of uremia.

ACKNOWLEDGEMENT

The assistance of Paul Chapman, M.D. and Isidore Selzer, M.D. in making available the charts and laboratory data herein reported, is gratefully acknowledged.

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Editorial Comment:

In the past many people were hospitalized in tuberculosis sanitoria for nontuberculosis lesions. Seldom today do we see hospitalization for tuberculosis with such conditions as sarcoid and histoplasmosis. However, the atypical mycobacteria can still be a fooler. It is also interesting to note that not all atypical mycobacteria are innocuous. JWM.

The Programmatic Aspects of The Michigan Regional Medical Program

BY ALBERT E. HEUSTIS, M.D., M.P.H.
EAST LANSING

The establishment of a special President's Commission and passage of Congressional legislation regarding cancer, heart disease and stroke will give great impetus to the efforts of sharing the knowledge of treatment of these diseases.

The Commission has submitted a report which includes the following two quotations:

> FIRST — "A significant number of Americans with these diseases (cancer, heart disease and stroke) die or are disabled because the benefits of present knowledge, in the medical sciences, are not uniformly available throughout the country."
>
> SECOND — "A creative partnersip must be forged among the Nation's medical scientists, practicing physicians, and all of the Nation's other health resources, so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions."

Then, in the opening section of Public Law 89-239 itself, we find the purposes of the legislation defined as follows:

> "Sec. 900. The Purposes of this title are —
> (a) "Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases;
>
> (b) "To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and
>
> (c) "By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

On the basis of these statements, what then is the involvement of the local physician in the Michigan Regional Medical Program?

INVOLVEMENT OF LOCAL PHYSICIANS

Everywhere along the line and at every level of policy and program development, the local physicians of the state have been well represented:

1. At the level of absolute control over what is submitted to Washington for funding, there are five local physicians on the Regional Advisory Group.
2. At the level of the Board of Directors who govern the affairs of the Corporation, there are two local physicians.
3. In the Professional Advisory Councils:
   Heart Disease has seven.
   Cancer has nine.
   Stroke has five.
4. On the Task Forces:
   Incidence and Prevalence has one.
   Continuing Education has three.
   Compatability of Educational Media has one.
   Methods and Evaluation has two.
5. Less active perhaps so far but with great potential for the future are the local physician representatives on the local advisory committees of our great universities.
6. We are asking that all those involved in the planning of projects be clearly identified in order to emphasize the need for the potential receivers — the learners and users of the in-

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Presented at the First Annual Conference for Michigan Health Planning, Detroit, February 23, 1968.

formation — to be involved in the development of those things designed to serve their local needs.

7. In our embryo State Plan, approved as a working document upon which to request funds, we see our medical centers working with local physicians in larger hospitals and we see those local physicians in turn — in ways acceptable to both — involving local physicians in smaller or community hospitals along the line of usual patient referral.
8. This Planning Conference represents the second time that officials and staff of the Michigan Regional Medical Program have been invited to present material to an official Michigan State Medical Society gathering and in addition the staff has met individually with a number of MSMS Committees and participated in an official MSMS called meeting to which the chairmen of all Medical Society Committees believed relevant were invited.

CURRENT STATUS

The Michigan Association for Regional Medical Programs has operated under a planning grant since June 1, 1967 — a relatively short period of time. While the University of Michigan initiated activity in July, other participants and the Central Office itself did not get staffed until the last quarter of 1967.

During this time the Central Office has:

1. Become organized and located.
2. Developed three Professional Advisory Councils, four Task Forces and two Ad Hoc Committees and provided staff work therefor.
3. Assisted those with an interest in developing programs.
4. Reviewed and made recommendations on projects submitted by the University of Michigan, the Michigan Heart Association, Michigan State University, Wayne State University, Michigan Department of Public Health and the Zieger/Botsford Hospitals.
5. Cooperated with the State of Michigan in the early planning phases of the development of the State Office of Comprehensive Health Planning.
6. Developed working liaison with the Minnesota and Wisconsin Regions regarding those problems of mutual interest.

The Michigan Department of Public Health has made a start on planning and developmental work and is developing a system of coordinated data collection and anaylsis to insure the comparability of all data collected in the region.

The University of Michigan has been doing central planning and coordination, trying to plan a Cancer Chemotherapy project, developing a program for Post Graduate Education of Nurses, establishing a Drug Therapy Information and Drug Therapy Analysis Reporting System and has started to plan for the training of non-professional personnel.

Michigan State University has established a Planning and Facilitating Office, and Wayne State University is getting started in the planning area, having just engaged their first personnel as of February of this year.

THE 1968-69 FEDERAL FUND REQUEST

Future activities include the projects which were approved by the Corporation's Regional Advisory

THE AUTHOR

Doctor Heustis, former director of the Michigan Department of Public Health, is the director of the Michigan Association for Regional Medical Programs (MARMP).

Group on February 2, 1968, and which have been sent to Washington for consideration of Federal funding.

Briefly summarized this project request consists of:

1. A central planning and administrative staff.
2. Planning staffs for the University of Michigan, Michigan State University, Wayne State University and the Michigan Department of Public Health.
3. The planning and initial development of an on-going population survey which will assess the state of health, provide up-to-date rates for small areas for morbidity and mortality, pinpoint populations and areas of concern and provide information on patterns of utilization of health services.
4. The development of an approach to automated screening.
5. A survey which will assess physicians' attitudes with respect to continuing education.
6. The development of a physician education program primarily for osteopathic physicians.
7. Community training programs for physicians and nurses in coronary care concepts.
8. Continued education for nurses, both at the universities and in the field.
9. Development of a system to provide drug information to physicians.
10. The study of ways in which to utilize and train non-professional personnel.
11. The evaluation of medical care services from the viewpoint of the patient and the planning for indicated improvements.
12. The planning of a continuing education program for dentists to improve services to patients with cancer, heart disease and stroke.
13. The planning for a community program for the management of stroke.
14. Assessment of the needs of low income populations.
15. Initiating a training program concerned with the diagnosis of hypertension.

CONCEPTS AND PRINCIPLES

Concurrently with the planning and development proceeding in some of our institutions, the Central Office has been working with the Professional Advisory Councils and Task Forces to develop general concepts and principles to guide staff action in the stimulation, development and review of project applications. These are presented here as an integral part of the emerging plan for Michigan's Regional Medical Program.

1. The goal of the Michigan Regional Medical Program is to advance the accessibility and the quality of health services available to individual patients throughout the region through regional arrangements designed to stimulate new patterns of cooperative action among physicians, hospitals, university medical centers, public health and voluntary health agencies.
2. In addition to universities, a wide range of health related community, district and statewide agencies will be encouraged to develop projects with the provision that applicants must have the ability to take full fiscal and operational responsibility for projects developed and have recognized competence in the area of concern or a demonstrable potential.
3. Projects to be considered for funding cannot be isolated activities but must relate to the overall development of Michigan's Regional Program.
4. In general, projects must provide for some immediate relevance for the improvement of patient care or for better utilization of manpower.
5. Projects must have as an objective the making of a practical contribution to the effective diffusion of knowledge throughout the region and to the lessening of the gap between knowledge and practice as it affects the care of individual patients. They should have some immediate impact in communities and hospitals not now affiliated with the medical schools and should be programmed to be geographically inclusive with an indication of the phasing anticipated for total coverage.
6. Projects must identify specific working interrelationships and cooperative arrangements that have been developed or anticipated with other agencies.

7. Patient care demonstration projects must either be replicable elsewhere in the region or have a clearly defined impact throughout the region on physician capability through training.

8. Projects will be concerned with those aspects of the subject diseases and of the health care system in which input of funds will result in maximum benefit in improving the care of individual patients.

9. Funding of projects relating to the care of low income urban groups will be encouraged.

PROCEDURES

To implement these principles, a consistent approach has been defined which, incorporated in the majority of projects funded, will organize what might otherwise be disconnected activities into a regional program.

1. Inasmuch as group consensus can be more effective in changing behavior than individual learning, the primary target for a decentralized approach to improved care of patients is the hospital staff.

2. Working with hospital staffs will be undertaken in conformity with a logistic regionalization concept whereby smaller or community hospitals relate along patient referral lines to larger district (sub-regional) hospitals or hospital centers and these in turn relate to a university medical center.

   The role of the medical center in a decentralized approach should be to work through larger or district (sub-regional) hospitals or hospital centers and their staffs, which in turn accept the responsibility for the involvement within their normal area of patient referral, of the smaller community hospitals and their staffs.

   Thus, a well organized district hospital (with a specialist staff and director of medical education) functioning as a training and service center will serve as a communication link between university and community hospitals, lessening the gap between knowledge in university medical centers and practice in community hospitals.

3. In all programs designed to improve patient care in order to have maximum impact, the effort should ideally be multi-disciplinary, providing for interrelated training of physicians, nurses and other personnel.

4. All applications must include specific assurances that continuing education offerings will be available to all medical and osteopathic physicians in the area regardless of hospital affiliation.

5. All projects will contain clearly stated objectives capable of realistic evaluation.

THE EMBRYO STATE PLAN

Within these principles and procedures, our embryo State Plan is as follows:

HEART DISEASE. Each district hospital or district hospital center will be encouraged and otherwise assisted in reviewing current practices regarding the handling of patients with acute coronary disease and wherever indicated will be assisted in developing and implementing an adequate concept of cardio-vascular care which will fit into its particular circumstances, with said district hospital or district hospital center and the medical staff thereof (with needed assistance from a medical school) accepting the responsibility of working with the smaller or community hospitals within its referral area, so that available new knowledge may be received in a fashion that will facilitate the improvement of patient care at the community level.

At least one training program in acute coronary care will be made available to each district hospital or district hospital center with the involvement of one or more community hospitals in each district area.

Comprehensive programs for the medical management of persons with hypertensive disease will be developed in the same way, with the district hospital or district hospital center serving as a resource for those medical specialties, diagnostic studies and treatment facilities not available at the community hospital.

STROKE. Comprehensive program for the medical management of stroke patients will be developed in the same manner as for heart disease and will include the pre-stroke phase on through the continuing care of post-stroke patients in long term care facilities, in their own homes or in nursing homes.

CANCER. Each district hospital or district hospital center will be encouraged and otherwise assisted in reviewing current practices in the primary diagnosis and treatment of patients with cancer, and wherever indicated will be assisted in developing an adequate program for the primary diagnosis and treatment of cancer patients.

With the help of, and the involvement of the medical staff of its district hospital or district hospital center, each community hospital will assess its own potential for the primary treatment of cancer taking into consideration the availability of specialist personnel and adequate diagnostic and therapeutic equipment, including nuclear medical components, and will determine a proper scope of services for itself and a proper relationship for patient referral between it and the district hospital or district hospital center.

With the assistance of a university medical school, each district hospital or district hospital center will develop competence in the curative and/or palliative aspects of cancer chemotherapy, and, through mutually worked out and acceptable mechanisms, share such knowledge and make its facilities and competencies available to the community hospitals in its area.

APPLICATION INFORMATION

Any group wishing to make an application to participate in Regional Medical Program funding by establishing a **cooperative working arrangement** may get started by just writing the staff a relatively brief letter outlining what they have in mind and with whom they plan to work cooperatively and sharing whatever information they have on timing and on costs. This will serve as a basis for initial staff discussions on a sub-regional or district hospital basis and after this, if feasible, a formal application may be prepared. We are at the present time seeking eight energetic men or women in the 10,000-14,000 dollar class to work in local areas to assist in project development.

THE VOLUNTARY NATURE OF THE PROGRAM

As a concluding note, everyone should be reminded that this is a **voluntary program** and that all goals and concepts herein discussed are most certainly subject to such modification or change as may be necessary to enable physicians to receive such help as they would like to receive and to receive this help in an acceptable and useable fashion. □

Office Management Seminar In Detroit, September 26

One of the features on the program of the MSMS Annual Session will be a Seminar on Office Management, on the afternoon on September 26, designed especially for newly-practicing physicians, residents, interns, senior medical students, and the interested wives.

The MSMS Liaison Committee with Residents, Interns, and Senior Medical Students, under the chairmanship of Norman Henderson, M.D., East Lansing, has developed a program to have maximum value in helping young Michigan physicians set up their practices according to flexible and efficient management principles.

Merck, Sharp, and Dohme pharmaceutical company is providing financial support for the seminar and will provide a special Office Management Handbook for participants in the seminar.

Michigan professionals who work closely with physicians in the business side of their practice will share their experience and counsel with the young doctors. Charles V. Brown, of Detroit, will speak on "Personnel Selection and Training;" C. Allen Willmar, Saginaw, will discuss "Setting Up Practice;" John K. Hoffman, Grand Rapids, will discuss solo practice and the various forms of partnership arrangements; R. Timothy Hogan, Ann Arbor, will speak on "What Shall I do With the Money I Earn;" and Carl King, Jr., Saginaw, on "Billing and Collection Systems." The first four speakers mentioned are all members of Black & Skaggs Associates, a Michigan firm which has been involved in professional management for physicians and dentists since 1932. Mr. King handles a billing and collection system for physicians in the Saginaw area.

Helps Dedicate School Named for Grandfather

Main speaker at dedication exercises of the Dr. Samuel A. Mudd Elementary School in Waldorf, Maryland, was Richard D. Mudd, M.D., of Saginaw, the grandson and only living physician descendant of Doctor Samuel Mudd, who lived from 1833-1883.

Doctor Richard Mudd, retired after 36 years as medical director of various divisions of General Motors, keeps busy by helping out several physicians and acting as a consultant.

WSU HONORS HALE

Ten Wayne State University professors with a combined total of nearly 300 years at the University were honored at the Service Recognition Tea June 16. The group included Esther H. Dale, M.D., Detroit, professor of pathology, 38 years.

State to Continue Study of Medical Education, Needs

The study of Michigan's educational programs for medical and allied health personnel will be continued by the Michigan State Board of Education, thanks to a recent grant of $98,680 from the W. K. Kellogg Foundation of Battle Creek.

In the past two years the Committee has been inventorying existing health manpower resources and educational capacities of the state to alleviate existing deficiencies and to plan for future needs.

Edwin L. Novak, of Flint, State Board of Education President, said that the grant will be used to subsidize salaries of the Committee's staff for two years, providing for a project director and assistant, two researchers and staff travel as well as office equipment and supplies.

In addition to working on a state plan for adequate health care education facilities, the 17-member Committee will help develop demonstration projects in allied health education such as medical technology and para-professional fields.

Thoughts of MD-of-the-Year:

In 1965, MSMS cooperated with the Michigan Tuberculosis and Respiratory Diseases Association to present Irvine H. Page, M.D., who was selected by the AMA in San Francisco as the "Outstanding Physician of the Year." Doctor Page, formerly with the Cleveland Clinic and now retired and living in Indianapolis, presented many provocative points in his 1965 Yates Address at MSU. His comments included these:

"Uncertainty lies now in what we are going to do for people, why we want them here and how long we want them alive.

"The last 40 years of science have done more to change our lives than all the rest of recorded time.

"More obesity begins at the family dinner table with children than ever originates later on.

"We are hereditarily conditioned organisms trying throughout our lifetimes to adjust to a hostile environment."

FIRST DO ADMITTED

Recently osteopathic physicians were offered full staff privileges at Sparrow, St. Lawrence and Ingham Medical hospitals in Lansing, and Ann Agustsson was the first osteopath admitted to the staff at Ingham Medical. She is a graduate of MSU and the Chicago osteopathic school.

MSMS RELEASES PUSH CAREERS IN HEALTH FIELD

High school graduates have been urged by MSMS news releases to consider health careers. In addition to describing the needs, MSMS President Bradley Harris, M.D., outlined a variety of health careers.

The news feature was headlined many ways. Among them:

Stockbridge Town Crier & Brief Sun: "High School Students Urged to Consider Medical Career"

Cedar Springs Clipper: "Many Opportunities in Field of Health"

Pioneer Press, Bear Lake, Manistee County: "More Medical Personnel Needed Everywhere"

Detroit East Side Express: "Seniors Urged to Consider Careers in Medical Field"

Farmington Enterprise & Observer: "Skilled Help Short In Health, Medicine"

Dimondale News: "Students Urged to Consider Medical Career"

Michigan Chronicle, Detroit: "Cite Unlimited Health Careers"

Livonia Observer: "Skilled Help Short in Health, Medicine"

Ingham County News: "Students Urged to Consider Medical Careers"

Montague Observer: "High School Students Urged to Take Medical Courses"

KAHN LEAVES U-M, JOINS HOWARD

Reuben L. Kahn, M.D., noted professor-emeritus of serology in the University of Michigan's Medical School, recently took over new duties as professor of microbiology at Howard University in Washington, D.C.

Previous to his new appointment, Doctor Kahn had been doing research at the U of M Kresge Medical Research Building and acting as research consultant in dermatology on the University staff.

Doctor Kahn achieved world renown when he developed a serological test for syphillis in 1923.

Doctor Kahn, who had been at the University of Michigan since 1928, was named to the Michigan Health Hall of Fame in 1965.

USPHS HELPS MSU

The federal government has granted $2,534,035 to Michigan State University to support construction of a $10 million Life Sciences Building for medical teaching.

The Michigan Legislature recently authorized $1 million for initiating construction with the understanding that an additional $3 million will be needed over the following two years. The Kellogg Foundation has granted $625,000 to support the construction.

Work is expected to begin this fall.

MSMS HELPS AREA REHAB CONFERENCE

About 100 physicians and interested lay people participated recently in an area Conference on Rehabilitation and Long Term Care of Elderly Patients at Saginaw County Hospital.

Sponsored by the MSMS Committee on Aging, Bay, Midland, and Saginaw county medical societies, and the Saginaw Veterans Administration Hospital, the conference dealt with both the professional and administrative problems related to rehabilitation and long term care of the elderly.

Chairman of the MSMS Committee on Aging, A. Hazen Price, M.D., Detroit, presided at the dinner which closed the conference.

New Rates Set For Nursing Homes

New rates for State payments to nursing homes under State-Federal medical assistance programs were set today by the Departments of Public Health and Social Services. The new rates, effective July 1, will be in force until June 30, 1969.

Reimbursement for facilities providing skilled nursing care will be $14 a day; those providing basic nursing care will receive $11 a day. Current rates are paid at four levels, from $10 to $16 per patient day, depending on the level of care.

The new rates are interim fees pending studies during the year based on standardized cost accounting. State categorization of nursing homes under proposed administrative rules, and reassessment of levels of care required by individual patients.

The Department of Social Services administers the assistance programs, but the Department of Public Health, under contractual agreement, sets daily reimbursement rates.

(From the Michigan Report by the Gongwer News Service.)

Doctor-Nurse Conclave Planned

The MSMS Committee on Nursing will sponsor an invitational Conference for Physicians and Nurses with an emphasis on "Strengthening Nurse-Physician Relationships" at the Michigan Education Association Conference Center at St. Mary's Lake near Battle Creek, Sept. 4-5.

HELPS SMOKING COUNCIL PLAN GP WORKSHOP

Oscar D. Stryker, M.D., Mt. Clemens, will represent MSMS on the planning committee for the Michigan Academy of General Practice Workshop on Smoking and Related Disease at MSU October 20.

MAGP has requested MSMS and the other organizational members of the Michigan Council on Smoking and Health to help plan the physician workshop.

SWEENY COMPETES IN TV BOWL QUIZ

Michigan participant in the "Medical Bowl Quiz," one of the unique features at the recent AMA Convention in San Francisco, was Donald N. Sweeny, Jr., M.D., Detroit.

Four teams, of three members each, competed with one another in giving quick answers to questions in the field of politics on a televised show. "Our team lost by two points, and the team which beat us went on to win the contest, so we didn't feel too bad about our showing," Doctor Sweeny commented.

REPRESENTS MSMS

A. C. Stander, M.D., Saginaw, represented MSMS at the recent annual convention of the Michigan Hospital Association. Doctor Stander, Saginaw, is a member of The MSMS Council.

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 22-26, 1968. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

BRADLEY M. HARRIS, MD
President

ROBERT J. MASON, MD
Council Chairman

JAMES B. BLODGETT, MD
Speaker

VERNON V. BASS, MD
Vice Speaker

Attest:
Kenneth H. Johnson, MD, Secretary

Consumer Price Increases in Health Less Than Year Ago

In the past few years consumer prices have displayed an even sharper advance because of the greater importance in the index of the cost of personal services, retail distribution, and other activities with a high labor content. April consumer prices were 4.0% higher than a year earlier, in contrast to the advance of 2.5% in the preceeding twelve months. The 1967 increase in consumer prices was the sharpest year-to-year rise in over 16 years.

Although hospital daily charges rose approximately 21.0% from March 1966 to March 1967, the following period (1967-68) only showed an increase of approximately 16.0%. Physicians' fees showed approximately a 10.0% rise during the period March 1966 to March 1967, however, the following period (1967-68) only showed a 4.0% increase.

In general, inflationary pressures are forecasted to persist in the months ahead with consumer prices continuing to increase.

Interested MSMS members can find detailed information in the June, 1968 issue of *Monthly Economic Letter,* published by the First National City Bank, New York; and from the monthly Consumer Price Index of the U. S. Bureau of Labor Statistics.

TO STUDY NURSING NEED

A joint study of Michigan's nursing education needs has been given approval of the State Board of Education. The study will be conducted by the Department of Medical Care Organization in the University of Michigan's School of Public Health and financed primarily through $50,000 of the Governor's Commission on Comprehensive Health Planning.

Leaves WSU Vice-Presidency, Scott to Travel, Teach Again

At the end of July, Gordon H. Scott, Ph.D., will leave for a three-month period of independent research in the fields of histology and electron microscopy at the University of British Columbia, following his recent retirement from the post of Vice-President for Medical School Development at Wayne State University.

"In his 23 years of distinguished service to the University," said WSU President William R. Keast upon announcing the retirement, "Doctor Scott has played a major part in making the Medical School one of the finest in the nation." After his work in British Columbia, Doctor Scott will continue his study for three months at the University of Washington, and for six months at Stanford University.

HE WILL THEN RETURN to Wayne State for a year of teaching in the department of anatomy. "I have been out of the classroom for more than 10 years and will look forward to going back," he commented.

Doctor Scott came to WSU in 1945 as a professor and chairman of the department of anatomy, served as Dean of the Medical School from 1950 to 1963, and from 1961 to the present he had served as Vice-President for Medical School Development.

DURING HIS TIME AT the school not only was the current building constructed, but definite plans were made for the new $56 million medical complex covering 25 acres of land near Grace and Harper Hospitals.

The groundbreaking last January of the $23.5 million Basic Science Building is considered by Doctor Scott as the "most gratifying experience" of his service to WSU.

"This made the relationship between the Detroit Medical Center and the University an assured thing," he said. "There was no turning back."

BESIDES HIS WORK AT the medical school, Doctor Scott served as president of the Michigan Health Council in 1963.

TO SURVEY FEES IN WAYNE COUNTY

MSMS Council recently approved a request from the Wayne County Medical Society that the MSMS Committee on Medical Socio-Economics, under the chairmanship of Dale L. Kessler, M.D., Grand Rapids, conduct a survey of fees by specialty and type of practice in Wayne County.

The survey will begin late this summer, will be of significant value to physicians not only in Wayne County, but throughout Michigan.

Council Selects Financial Board

The MSMS Council recently appointed a five member Board of Managers whose duty will be "to invest, re-invest, buy, sell, trade or otherwise, acquire, dispose of or manage Society assets assigned to its care with the objectives of achieving a combination of growth income and stability," according to the official Council minutes.

Appointed to the Board were MSMS Treasurer John R. Ylvisaker, M.D.; MSMS Finance Chairman Robert K. Whiteley, M.D.; C. Allen Payne, M.D., and Ross V. Taylor, M.D., members of The Council, and Thomas H. Wagner, investment counselor.

The Board was authorized by the special session of the House of Delegates.

Emergency Care Plan Tested?

The medical staff of every Michigan hospital should take the leadership to be sure that the hospital emergency medical care plan has had a recent trial run.

That contention is being voiced by The MSMS Council and the MSMS Committee on Public Relations in communications to every component medical society. The need for preparedness was explained in an editorial in the July issue of *Michigan Medicine* by Brock E. Brush, M.D., MSMS PR chairman.

Chorioretinitis: Its Etiology and Therapy

Abstract: Chorioretinitis is a major cause of blindness in the United States today. The usually obscure etiology of this disorder frequently requires a multispecialty approach to the problem. This presentation discusses some of the currently prevailing concepts of the cause and treatment of chorioretinitis and suggests a program of etiologic evaluation.

BY CONRAD L. GILES, M.D.
DETROIT

Inflammatory diseases of the eye account for more than 10 per cent of all blindness in the United States. Chorioretinitis or inflammation involving either the chorid or retina is responsible for nearly half of these lesions. Since the evaluation of patients with chorioretinal inflammation frequently involves several specialists, an understanding by all physicians of the current ophthalmologic management of this entity is obviously important. This paper will discuss some of the more important aspects of the etiology and therapy of this disease.

Because the nature of the visual process precludes the usual etiologic investigation of inflammatory processes, the clinician is severely handicapped in his attempt to isolate specific pathogens. Indirect laboratory and clinical investigation must be employed since biopsy or culture of the inflammatory focus will result in the loss of the eye. Although the microscopic examination of enucleated globes has proven significant in suggesting possible etiologies and avenues for further research, this method of evaluation has little direct value in the clinical approach to a given inflamed eye. In arriving at a presumptive diagnosis the clinician must therefore depend upon blood studies, skin tests, radiologic examinations, urinalysis and stool preparations for help. With these diagnostic tools it is possible to suggest an etiology in approximately 50 per cent of all patients with chorioretinitis.

PROVEN AND COMMON ETIOLOGIC AGENTS

TOXOPLASMOSIS is the most common presumptive diagnosis recognized in posterior uveitis at the present time. Toxoplasma gondii, an intracellular parasite is involved in two separate clinical syndromes: congenital and acquired toxoplasmosis. Central and peripheral chorioretinitis is seen in both groups of affected patients (Figure 1). The diagnosis is based on a positive toxoplasmin skin test and/or confirming serologic testing (methylene — blue dye study of Sabin and Feldman or hemagglutination) with the clinical picture of an exudative chorioretinite.

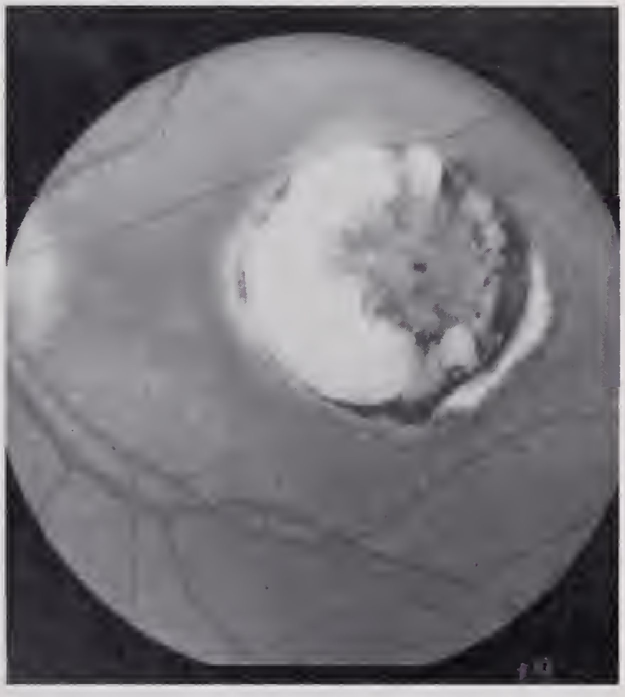

FIGURE 1: Macular chorioretinitis in 14-year-old girl with normal visual acuity and healed peripheral lesions in the contralateral eye. Sabin-Feldman titer positive 1:1024, positive toxoplasmin skin test both present.

The author is a clinical instructor in the Department of Ophthalmology, University of Michigan and Wayne State University.

SARCOID — Although involvement of the anterior segment of the eye with uveitis is more common than chorioretinitis, the characteristic fundus picture (Figure 2) in association with the systemic disease permits the clinician to diagnose another small segment of intraocular inflammation.

SYPHILLIS can involve the choroid and retina in both congenital and acquired syphillis. The disease may be either disseminated or localized and show large atrophic areas of retinal destruction. (Figure 3) The recent use of the FTA absorption study in the diagnosis of ocular syphillis suggests that a larger percentage of posterior uveal retinal disease is on a luetic basis than previously thought.

TUBERCULOSIS, unless miliary in type, is probably a very rare cause of posterior uveitis. Isolated cases have been reported and the diagnosis must rest upon the very tenuous basis of a positive tuberculin skin test in the presence of chorioretinitis.

TOXOCARA LARVAE are the most important agents involved in nematode infestation of the eye. Isolated posterior retinal lesions and vitreous abscesses, as well as iridocyclitis can be produced by this larvae. Skin testing and serologic data are unreliable and the diagnosis rests on the clinical appearance of the lesions in the pediatric age group.

UNPROVEN AND CURRENTLY FASHIONABLE ETIOLOGIES

Fashions are not limited to the haute couture of Paris and New York and choriortinitis, along with all disease of obscure etiology, has its fashions.

HISTOPLASMOSIS is currently the most widely unproven diagnosed cause of chorioretinitis. The characteristic lesion (Figure 4) is seen in a high percentage of positive histoplasmin skin reactors. This forms the basis of the diagnosis.

AUTOIMMUNE — For several decades the possibility of hypersensitivity and allergic phenomena has been suggested as an important cause of

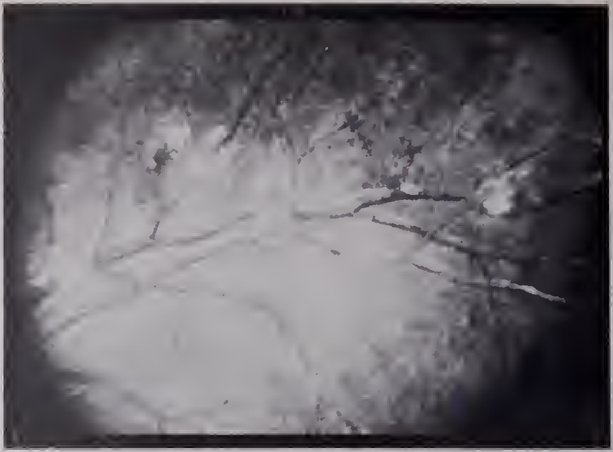

FIGURE 2: Retinal sarcoidosis with characteristic periphlebitic lesions referred to as "candle-wax droppings" in the ophthalmic literature.

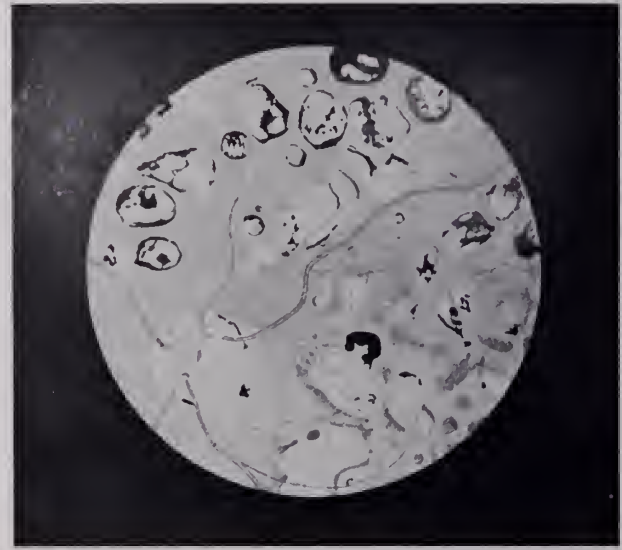

FIGURE 3: Disseminated, atrophic, healed areas of chorioretinal destruction in eye of patient with acquired syphillis.

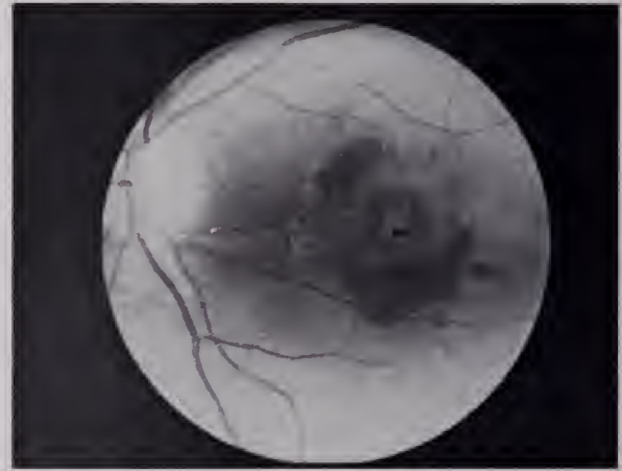

FIGURE 4: Central cystic macular elevation with surrounding collarette of hemorrhages in 35-year-old male. A positive histoplasmin skin test, negative complement fixation and chest film were present.

chorioretinitis. The significant clinical improvement following the use of antimetabolite therapy in patients with uveitis has increased the interest in this area though, once again, specific proof is lacking.

PROVEN BUT OBSCURE ETIOLOGIES

Several systemic diseases have as their components the sporadic occurrence of chorioretinitis. When the chorioretinitis occurs during the active phase of such an illness, the diagnosis, although once again presumptive is relatively simple. Unfortunately the temporal relationship between the uveal and systemic manifestations of the disease is variable. The following is a list of such diseases and is mentioned largely for completeness since lack of space and the relative obscurity of these entities in the United States does not permit a detailed discussion of each etiology.

a. Cytomegalic inclusion disease
b. Leptospirosis
c. Leprosy
d. Blastomycosis
e. Coccidiomycosis
f. Candidiasis
g. Cysticercosis
h. Onchoceraciasis
i. Brucellosis

ETIOLOGIC EVALUATION

The enormous task of ruling out all of the possible known causes of chorioretinitis in a given patient is expensive, time-consuming, unpractical and probably impossible. It is therefore necessary to formulate a pragmatic, somewhat flexible etiologic program in an attempt to isolate the etiology of chorioretinitis in as many patients as possible. The following program has been evolved to fill this need.

1. General physical examination by the generalist, pediatrician or internist to determine any associated systemic disease.
2. Skin testing — hystoplasmin, toxoplasmin, tuberculin and in endemic areas coccidioiden antigens are placed.
3. Blood studies should include a serological test for syphillis (FTA absorption), the complement fixation studies to histoplasmosis, coccidioidomycosis, blastomycosis and brucella hemagglutination and total serum protein with A/G ratio.
4. X-ray examination of the chest.
5. Stool examinations for ova and parasites in selected patients.

TREATMENT OF CHORIORETINITIS

The cornerstone of treatment of chorioretinitis is systemic corticosteroids. The use of this nonspecific anti-inflammatory agent is the only drug used in those patients in whom no etiology is found. Where specific presumptive etiologies are detected, appropriate chemotherapy is added to the corticosteroids.

Toxoplasmic chorioretinitis responds to Pyrimethamine (Daraprim-Burroughs-Wellcome) sulfadiazine and folinic acid (Leukovorin, Lederle). Large doses of penicillin and ampicillin are given to patients with luetic chorioretinitis while isonicotinic acid hydrazide (INAH) either alone or in combination with streptomycin and/or para-amino salicylic acid (PAS) should be employed in presumptive tuberculosis chorioretinitis. Thiabendazole is indicated in selected cases of toxocariasis and the indicated antimicrobial agents should be administered when any of the more obscure etiologic entities is suggested.

SUMMARY AND CONCLUSIONS

The etiology of chorioretinitis is frequently obscure. Because of the blinding potential of this inflammation, however, the ophthalmologist, together with his medical colleagues is commited to thoroughly evaluate these patients. The author has presented some current concepts concerning this entity and has suggested a program of etiologic evaluation based on currently available information. ☐

Editorial Comment:

As the author points out, Chorioretinitis still escapes etiological diagnosis in approximately 50% of the cases. The author has outlined an excellent scheme for the other 50%. Unfortunately the Generalist, Internist and Ophthalmologist will still rack their brains etiologically and therapeutically in the residue. The approach given by the author will certainly help those who have to cope with this problem. JWM.

Fetal Electrocardiography In Labor: A New Scalp Electrode

BY GEORGE E. LA CROIX, M.D.
DETROIT

Electronic monitoring of the fetal heart during labor expedites the early diagnosis of fetal distress and serves as a guide for its correction or termination by appropriate intervention. Experience suggests that intrapartum and perinatal loss may be decreased by wider application of continuous monitoring particularly in pregnancies at "risk."[1, 2] Correlation has been demonstrated between the fetal heart rate, acid-base status of scalp or cord blood, and the Apgar score.[1, 2, 3]

Sound and electrocardiography are popular approaches to clinical monitoring, but have serious limitations. Techniques utilizing multiplication of sound frequency and filtration of noise are superior to sound amplification alone,[4] but remain vulnerable to the noise of contracting uterine muscle and patient agitation. Experience with the fetal cardiac sound complexes is as yet inadequate for meaningful interpretation. Fetal electrocardiography secured through the abdominal placement of electrodes produces mixed maternal and fetal signals. Cancellation of the maternal signal is required by additional instrumentation before electronic counting can be employed. Under the best of circumstances, only the QRS wave of the FECG is identifiable, limiting its diagnostic value. In addition, the fetal signal may be entirely obliterated by the extraneous noise of the contracting abdominal and uterine muscle of the parturient in active labor.

Electrocardiographic techniques in which one or more electrodes make contact with the fetus produce a strong fetal signal. Resulting FECGs have minimal or absent maternal signal contamination and are therefore immediately suitable for electronic rate meters. Occasionally, detail is of sufficient clarity to permit analysis of the fetal electrocardiogram.[5] In labor, the presenting part of the fetus provides a point to which electrodes may be secured. Membranes must be ruptured, limiting such monitoring to the active phase of labor. Several types of electrodes consisting of prong-like, suction cup or modified skin clip varieties have been described for this purpose, but possess individual weaknesses which have limited their clinical usefulness.[5-9] Some are bulky or rigid, difficult to apply, require special aptitude, applicators or endoscopes for insertion, connectors and additional ground wires to the maternal thigh or ankle.[5-9]

A NEW ELECTRODE is described which eliminates many of the undesirable features of other types. Trial in over 150 patients has confirmed its safety, reliability, simplicity, ease of application, and clinical usefulness.

THE ELECTRODE

Figures 1, 2 illustrate the electrode. The negative electrode is a fine silver plated angle hook, similar in calibre to a 25-gage needle. The positive pole located one centimeter distal to it consists of a pure silver wire wound twice around the polyolefin jacket. Two fine wires within a continous tinned copper shield conduct the fetal cardiac potential from the two electrodes. The electrical circuit is completed through the vaginal secretions and amniotic fluid. The external shielding serves as an effective ground by continuous contact with the vaginal mucosa.

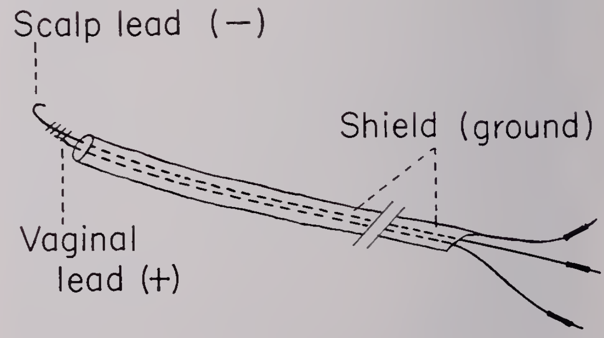

FIGURE 1: The negative and positive wires conduct the fetal cardiac potential from their respective pole. The wires are insulated from the outer sheath, which by maintaining contact with the vaginal mucosa, serves as the ground.

The author is associated with the Department of Gynecology and Obstetrics of the Wayne State University School of Medicine.

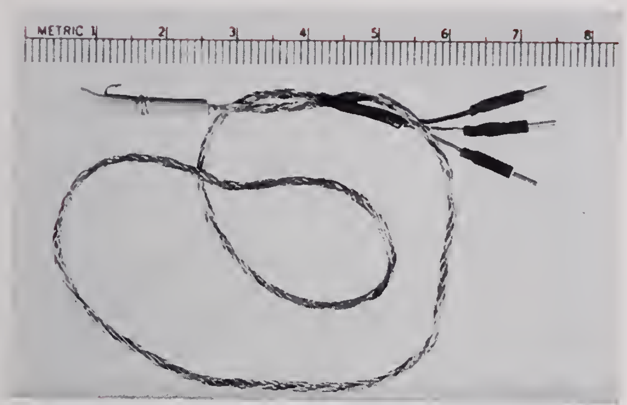

FIGURE 2: The leads are composed of fine flexible wires of 12-inch length. The overshoot of the polyolefin jacket helps to prevent motion of the electrode. The 3 micro connectors facilitate rapid connection to a lightweight patient cable.

CONSTRUCTION MATERIALS

All materials utilized in the construction of the electrode are available through local electronic and jewelry stores. The angle hooks are silver plated by a local electroplating concern.

1. #32, 2 conductor shielded Belden wire, #8429.
2. Silver wire, pure 26 gage.
3. Micro connectors, Amphenol, Reliatac-PO2.
4. Polyolefin tubing — Alpha F.I.T. — 300 — 1/8″ brown.
5. Shrink tubing — Alpha F.I.T. — 105 — 1/16″ white.
6. Angle hooks — Mustad-Viking — No. 94840 — #16 (extra fine).
7. Epoxy glue (Elmers).
8. Clear epoxy varnish.

METHOD OF CONSTRUCTION

The external shielding is stripped back one inch at either end of a 14-inch segment of wire, the excess shielding wound tightly at the distal end, and clipped off at the electrode end. Micro connectors are soldered to the shielding and the two exposed wires. A ½-inch segment of 1/16-inch white Alpha tubing is then heat shrunk over each solder junction for added durability. Attention is then directed to the construction of the electrode. The eye of the angle hook is removed, and the hook soldered to the black wire (negative pole). A 1½-inch segment of 26-gage silver wire is soldered to the red wire (positive pole). Both junctions are coated with epoxy glue. A one-inch segment of polyolefin tubing is perforated with a large needle at the ¾ and ½-inch mark, placing the holes at right angle to each other. The angle hook is inserted into the tubing and then through the ¾-inch opening. The silver wire is introduced through the opening at the ½-inch mark. The tubing is then heat shrunk forming the polyolefin jacket. The silver wire is wound twice tightly around the jacket one centimeter distal to the angle hook. The entire electrode — excluding the tip of the hook — is coated with clear epoxy varnish, air-dried and oven-baked at 200°F for one hour. The silver wire is lightly filed over a small area to expose the silver.

TEST PROCEDURES

Electrodes are tested prior to use for polarization noise and uniformity as outlined by Hon.[5] The response of the electrode when immersed in .9% saline in a shielded enclosure and tested by a suitably sensitive preamplifier generally reflects the noise level encountered in the in vivo studies. Electrodes are tested only at rest since the external shielding produces artifacts with agitation not seen in clinical use. An electrode with baseline drift or transient spikes of less than 25 microvolts is suitable for fetal electrocardiography. Excessive noise may be eliminated or decreased to an acceptable level by lightly electrochloriding the electrodes in .9% NaCL solution. Figure 3 illustrates the effect of electrochloriding. Any electrode with shorting between wires, lack of electrical continuity or excessive noise is discarded. Figure 4 illustrates the clarity of the FECG.

The amplitude of the FECG in 50 patients is illustrated in Figure 5. The QRS wave has ranged from 75 uv. to 800 uv. with the average 250 uv.

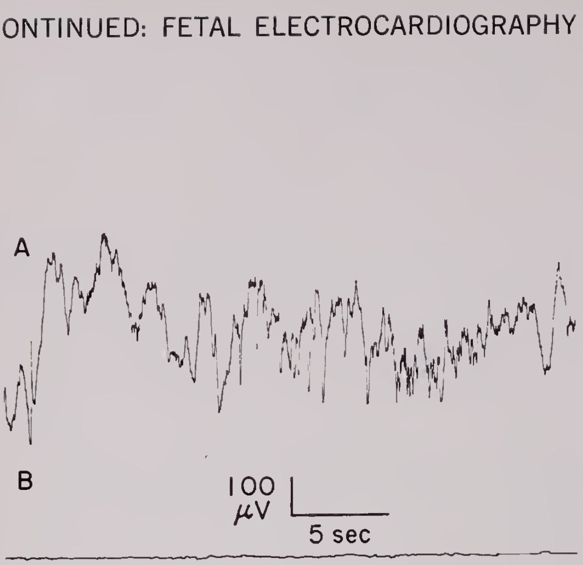

FIGURE 3A: Basic polarization noise of the Ag-AgC1 electrode tested in .9% saline. The drift and spikes seen in the test environment may be reflected in the FECG. Paper speed 5 mm. per second. Recorded on a Sanborn Recorder - Model 2100.

FIGURE 3B: Note the improvement in the noise level when the positive and negative electrodes are electrochlorided for one minute at 1½ volts. Paper speed 5 mm. per second. 100 uv. calibration is the same in A and B.

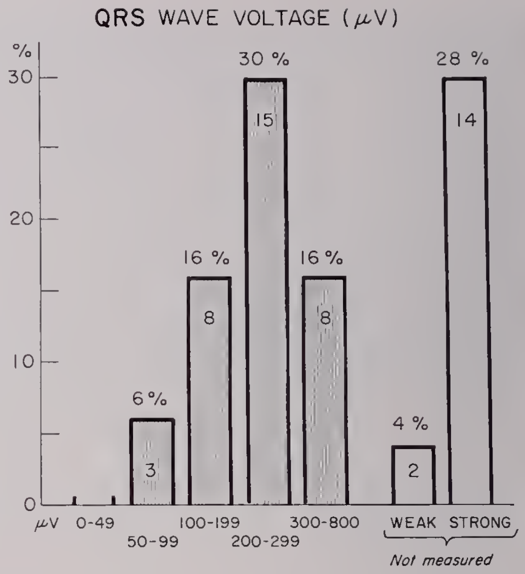

FIGURE 5: The distribution of fetal electrocardiograms in 50 patients according to the amplitude of the QRS wave. The weak signals (under 200 uv.) and strong signals (over 200 uv.) were calibrated by visual estimation of the oscilloscope image. The remainder were accurately calibrated from permanent records.

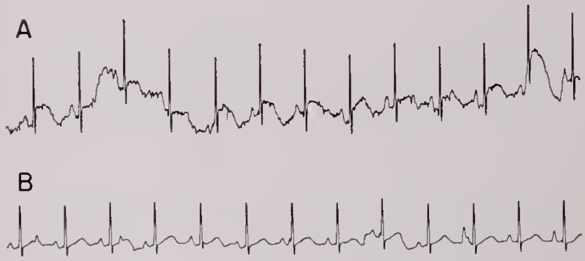

FIGURE 4A: If the electrodes are not electrochlorided, a "noisy" FECG may result. The QRS wave measures 250 uv. Paper speed 25 mm. per second. This FECG is suitable for cardiotachometry, but of less value for analysis of FECG components.

FIGURE 4B: A "quiet" FECG followed electrochloriding the positive and negative electrodes. The QRS wave measures 400 uv. Paper speed 25 mm. per second.

CLINICAL USE

The electrode has been inserted at virtually any stage, station (minus 3 to plus 3) or dilation in labor which permits passage of the uterine packing forcep. Application usually requires less than one minute. The fetal membranes must have been ruptured prior to application or amniotomy is performed as soon as obstetrical conditions become favorable. The distal polyolefin jacket is grasped by the clamp, introduced under aseptic precautions in bed using two fingers of the opposite hand as a guide (Fig. 6). The angle hook is placed in apposition to, and gently set into the scalp, taking care to avoid suture lines or fontanelles. The small diameter of the hook prevents penetration deeper than 2 to 3 millimeters. Usually applied to the fetal vertex, it has produced clean tracings in five infants presenting by the breech. No injury has occurred to mother or infant in over 150 applications.

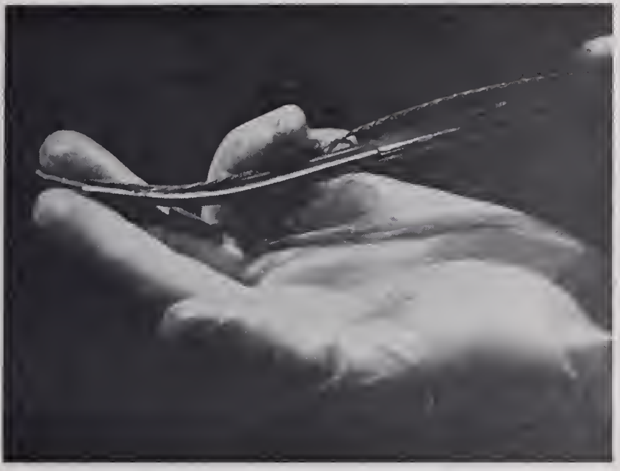

FIGURE 6: The distal end of the polyolefin jacket is grasped by the uterine packing forceps, introduced vaginally under aseptic precautions, using the fingers as a guide.

Although the best results with an electrode are obtained on the first occasion, many have been used four to five times. Special care is not necessary when cardiotachometry alone is contemplated, but thorough cleansing, retesting and chloriding are desirable for optimal detail of the FECG. Conventional autoclaving will not injure the electrode.

COMMENT

Investigation of the fetal electrocardiogram and its application for electronic heart rate counting have clinical and research value. The small size of the angle hook electrode makes possible its use from early in the first stage of labor through the hazards of the first and second stages when the infant is at major risk. The fetal cardiac complex may be permanently recorded for analysis, displayed on an oscilloscope, or used to trigger a cardiotachometer or suitable audio visual system.

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Editorial Note:

Fetal monitoring during labor will do a great deal to lower fetal mortality, especially in such cases as prolonged and difficult labor as well as prolapsed cord. People in various centers are working on fetal oximeters but as yet I do not know of any practical set up. The author presents a simple and apparently excellent method for fetal ECG monitoring. It is to be hoped that many hospitals will adopt this procedure. JWM

COMING EVENTS

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

COMMUNITY HEALTH WEEK PLANNED FOR OCTOBER

MSMS plans for Community Health Week, October 20-26, are rapidly developing. MSMS is planning a program for a statewide meeting to focus on the major problems in medical service to rural areas of Michigan, the AMA rural emergency care plan, the problems of health manpower, and other related topics. The meeting is an example of how Community Health Week, Oct. 20-26, can be adopted to focus on local needs.

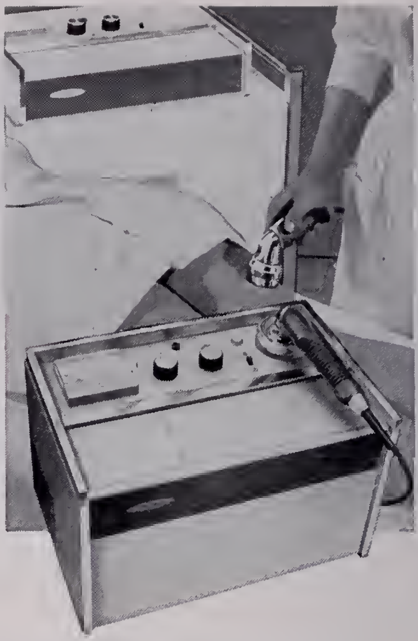
Health Careers is one of three topics suggested by the American Medical Association, the others are drug abuse and physical fitness.

A promotion kit is available to help county societies prepare for Community Health Week. Copies can be obtained from MSMS headquarters.

The Michigan Health Council and the Michigan Association of the Professions are cooperating.

MICHIGAN MEDISCENE

Aug. 21 — The Council, MSMS Headquarters, East Lansing (Tentative)
Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit
Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit
Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit
Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit
Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor
Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron
Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit



Another step forward in Ultrasonics The Burdick UT/420 Continuous or Pulsed Ultrasound

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These Firms Make '68 Annual Session Possible without a Registration Fee

One of the colorful and educational aspects of the MSMS Annual Session in Detroit this September will be the interesting array of exhibits.

MSMS leaders say, "Take time to inspect each one — not just a casual look — but a real indepth study. You will be surprised at the wealth of new information they will offer you."

Following is a list of the firms who will be presenting displays at the 1968 MSMS Annual Session. Doctors are urged to make a special effort to visit each booth to personally express appreciation and to ask questions.

Income from the leasing of exhibit space makes it possible for MSMS to present its excellent Annual Scientific Session without a registration fee.

The intermission periods between scientific sessions will provide excellent opportunities to study the exhibition. The registration desk, meeting rooms, and exhibits will be conveniently located on the same floor as the meetings.

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

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Ortho Pharmaceutical Corporation
Parke, Davis & Company
R. J. Reynolds Tobacco Company
A. H. Robins Company
Roche Laboratories
J. B. Roerig & Company
Rollins Shoes, Inc.
Wm. H. Rorer, Inc.
Ross Laboratories
Sandoz Pharmaceuticals
W. B. Saunders Company
Schering Corporation
G. D. Searle & Company
Seven-Up Developers of Michigan
Sherman Laboratories
Siemens Medical of America, Inc.
Smith, Kline & French Laboratories
E. R. Squibb & Sons
Standard Process Laboratories
Ben P. Stratton Agency, Inc.
The Stuart Company
Stryker Corporation
Syntex Laboratories, Inc.
S. J. Tutag & Company
United States Tobacco Company
Wallace Laboratories
Warren-Teed Products Company
Westwood Pharmaceuticals
Winthrop Laboratories, Inc.

Of Partnerships and Politics

BY D. BONTA HISCOE, M.D.
LANSING

A good and rather outspoken friend of mine recently cut off a conversation on the general subject of medicine's future by saying, "I'm sick to death of hearing about what they'll do if we don't."

This physician happens to be more well-informed than the average. He knows that medicine is now considered a right and not a privilege. He is aware of the recent great progress in medicine and the revolution of rising expectations. He is aware of the recent avalanche of medical legislation — Medicare, Heart Disease, Cancer and Stroke, and Comprehensive Planning.

Inside he knows that his remark only ends the conversation — it doesn't solve the problem.

The best answer I know to his attitude was presented by Dr. Wallace S. Sayer, Chairman of the Department of Public Law and Government at Columbia University, at a recent meeting sponsored by the AMA. Speaking about the American political system as an environment in which we must work, he stated: "What I would like to do is to welcome you to a world you've been shy about entering, but in which you have now arrived, and to reassure you that the rules of survival can be learned and that the mortality rate is low." He pointed out that the decision-making system of our country is pluralistic, that there is room for all, and that there are many centers of power competing with each other. He said, "When it comes to important public policy, politics are inescapable. Decisions are reached in this system . . . . . by bargaining among competing centers of power. 'Bargaining', if not quite a respectable word to this audience, is an indispensable skill in the system. One way to unlock the mysteries of what happened to the A.M.A. in the last ten years, might be to say that an indisposition to bargain means defeat. A successful participant in this system must be prepared to bargain." He then explained that all decisions are tentative, never final, and that an essential part of bargaining in this system is alliance-building.[1]

In other words, if you're in the water, whether you're fish, fowl or mammal, you must swim.

The background for my remarks has already been well laid by James T. Howell, M.D., at last year's MHA Medical Staff, Trustees and Administration Forum at Mackinac Island in June of 1967. He said then that both doctors and hospitals are dedicated to the eradication of human ills, and to maintaining freedom from direct controls. If either one falls under central control, so does the other. And yet, doctors and hospitals are not united in their efforts.[2] May I suggest some practical first steps to accomplish this end?

WHAT'S HAPPENING

Our medical care system has recently been picked apart, studied, analyzed, and evaluated by a new breed called "problem-solvers", whose unsolicited attention is both flattering and disconcerting.

In the past few years extensive studies have been carried out by many individuals and agencies who have worked under a variety of auspices. Their principal questions were: "How is the job being done?"; "Is the whole need being met?"; "Can it be done better, now, and in the future?"

Some of their reports will have considerable bearing on the future of medicine. A few of the most significant reports are:

The Folsom Report — entitled, "Health Is A Community Affair."[3]

The Coggeshall Report, focusing on medical education and the future.[4]

The author, president of the Health Planning Council of Michigan, presented these remarks at the 1968 Medical Staff — Trustee — Administrator Forum at Boyne Mountain Lodge.

The Millis Report, which introduced the term, "primary physician."[5]

The report of the National Advisory Commission on Health Manpower, released in 1967.[6]

The immediate reaction of those being poked and probed is similar to that of a patient having a barium enema. He would like to disparage, discredit and dismiss the whole thing as unnecessary tampering or meddling. This is, of course, unbelievably short-sighted.

CERTAIN POINTS MUST BE CONCEDED

First, there are problems that have stimulated these studies. We may not agree as to how many there are or as to their significance, but there are problems.

Second, there are enormous pressures to search for answers. Manpower and facilities are in short supply and the demand is great, creating, in effect, a demand-pull type of medical inflation. In order to cope with the current and inevitable increase in cost, the organized consumers (the government, labor, business and the insurance companies) are expressing firm demands for efficiency and cost control. Some things new, different and better, are expected.

Third, legislation has been passed, which shows that they mean business. More will come.

Fourth, we must concede that these people (doing the studies) are highly intelligent, thoughtful, and imaginative. They represent disciplines and approaches foreign to the medical community. They may on occasion be misguided or unenlightened, but they are smart.

CONCLUSIONS OF THE CRITICS

FIRST, they say our medical care system today is actually a "non-system."[7] A recent *New England Journal of Medicine* editorial succinctly puts it this way: In medical care "vast and fruitful attention has been paid to research and development, but marketing, sales and packaging have been sadly neglected."[8] There should be a system.

SECOND, they say that the community interest should take precedence over any special interest group, be it hospital, physician, research institution or medical school.

THIRD, the scope of medical care should be increased to include total health care, rather than remain chiefly crisis-oriented.

FOURTH, the primary center for medical care on the local level should be the hospital rather than the physician's office.

FIFTH, though the types and roles of physicians in the future have not been well-defined, physicians are being firmly encouraged to develop various types of coordinated or group practice, and to utilize ancillary help.

So much for the views of our critics. Let me now respond with my own personal views as to how we, doctors and hospitals together, should respond to these challenges.

UNITING THE EFFORTS

Physicians are essential in medical care, but they cannot practice today's medicine in a vacuum. They need hospitals in order to ply their trade satisfactorily. On the other hand, hospitals are not independent health care units either — they need doctors. I know of very few hospital administrators who could practice good medicine, and there are many bankers and salesmen who will attest that physicians are wretched businessmen.

In past years physicians and hospital administrations have developed a guarded relationship by carefully defining their respective areas of responsibility. So long as each did his job well, the hospital thrived, and its position in the community was assured. But in the future, if current thinking prevails, the autonomy of each hospital is threatened with integration into a community-wide system, while at the same time, the sharp distinctions between hospital administration and medical practice are becoming blurred. As new regulations come from all directions, hospital administration is being given more responsibility for the quality and quantity of medical care. For example, hospitals are now legally liable for the medicine practiced within their walls. And while the hospitals are thus pushed into medical concerns, the Commission on Health Manpower has recommended "an increase in the physician's responsibility for the successful and economical management of the hospital operations" — that he have a financial stake in the management of the hospital, and be included on the boards of control!

It is clear, then, that physicians and administrators are actually both essential parts of a single organism. And it is time for them to function this way.

It is time for us to give up prejudices and animosities inherited from the past. These are luxuries we cannot afford. It is time to learn the rules of the new ball game. It is time to show some real initiative. It is time for medical societies and hospital associations at all levels to realize that by working together they can accomplish much more, both for their communities and for themselves.

Physicians' services account for about 25% of the health care dollar. Hospital expenditures account for 33%. If we include the drugs we dispense, about two-thirds of the medical care dollar passes through our hands. Together, we represent the system (or "non-system") as it is today, and we are responsible, in large part, for both its successes and its failures.

PARTNERSHIPS of all kinds are the "in" thing today. Congress recently named a bill, "Partnership in Health." College kids work like crazy at it. Why shouldn't we?

This combination would put together the "Doers" of medicine. If we could work out constructive and responsible common stands on major issues, we could have tremendous influence. Then within the medical system, we, the "Doers," could more effectively stand up to the planners, researchers and educators. In the political arena our voice would command more attention than the efforts of our separate trade associations. We could form a powerful nucleus for practical, reasonable and evolutionary change.

In actual fact, no one group, nor single partnership, will call the majority of the shots, much as we might like to. That's why even a partnership such as I propose should promptly build cooperative arrangements with the many other voluntary groups interested in the future of health care.

We are told that the ideal and ultimate solution should be a partnership between the whole voluntary sector and the government. If this be the case, I strongly urge that our half of the partnership be pulled together firmly and strongly, be solidly built and well stacked.

SUGGESTIONS

I feel that it is urgent to push this type of working coalition into being soon. I'm therefore going to take a few minutes to make a few firm and concrete suggestions.

On the national and state levels, dormant and atrophic liaison mechanisms should be shined up and reactivated. If they have vanished, active new liaison committees should be established — not to be polite and exchange platitudes — but to explore all areas and means of cooperative action. Speak to the delegates of your respective associations and give them a push.

In the meantime, County Medical Societies should incorporate the know-how of Hospital Administrators into their deliberations. Administrators should be an integral part of all hospital relations committees. Administrators should also be included as part-time members or consultants on other appropriate committees. The hospital regional associations should do the same thing on their part.

SPECIFICALLY, HERE are some things I think we can work on:

FIRST, continue to produce useful conferences such as this Staff, Trustees and Administrators Conference, developing understanding and new ideas.

SECOND, coordinate some public education programs, particularly those promoting health careers, discussions about current health matters, and public health.

THIRD, by combined effort, more effectively support (or challenge) new legislation.

FOURTH, cooperatively contest questionable court action in order to modify an influence with an ever-increasing impact on medical practice.

FIFTH, participate in planning efforts together, so that we can propose voluntary solutions to health care problems. The Health Manpower Commission Report acknowledges that the Federal Government alone is not big enough nor rich enough to solve the problems of health care for the whole country. They are anxious to share this responsibility, but the question has been, "with whom?"

When one looks at the strong competition — State Government and Regional Medical Programs — one quickly realizes that within the voluntary sector petty rivalries are stupid, irrational and self-defeating. The voluntary sector must rise to the challenge. The opportunity may be brief!

Representatives of the voluntary sector must demonstrate the foresight to support significant efforts; we must have the maturity to evaluate new ideas dispassionately; and we must demonstrate the stature and courage to carry out worthwhile ideas. Voluntary agencies are best able to maintain flexibility in the face of multiple problems. The mere presence of a strong united voluntary sector with its great intellectual and political resources would be certain to win a much more significant role in future planning.

The Health Planning Council of Michigan, appropriately supported and developed, could be a strong spokesman for our partnership, since it is supported not only by physicians and the hospital associations, but also includes other health-oriented groups and interested laymen. This organization's sole function is to promote local and regional planning, and in no way does it presume to dictate to nor supplant the local planners.

SIXTH is the area of common concern — money. Ironically, in the future we will have to protect medicine's share of the federal pot of gold. Currently, federal money is abundant. Hospital and physician income will be increasingly subsidized by government. Should social interest shift and other pressures threaten curtailment of this support, the protection of this subsidy on which future budgets, personal and hospital, will depend, will become an increasingly important project for everyone interested in health care.

CONCLUSION

The dictionary defines intelligence as "the ability to respond successfully to new situations." This offers a great challenge to our collective conceit.

Let's see to it that the integrated medicine of the future truly fills the patient's needs, and maintains flexibility in the process.

Let's accept the challenge. Think big. Work hard. Together.

And above all, let's see to it that we are at least co-captains of the comprehensive ship.

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The Need for Utilization Review

BY LOUIS F. HAYES, M.D.
VICE PRESIDENT, MEDICAL AFFAIRS
MICHIGAN BLUE SHIELD

A previous article published in *Michigan Medicine* dealt with the "what?" of utilization review. A quite simple definition was reached — measurement of the use of medical service. Equally as important, the objective was also defined — the best medical care for the most people at the lowest cost.

To attain a thorough understanding of utilization review (the ultimate objective of the planned series of articles) the next question to be answered is "Why?" What is the need for utilization review? What are the factors that compel us to this extracurricular task? Why the urgency?

FIRST, LET US IDENTIFY THE factors involved and then evaluate their influence. And, once again, let us simplify it as much as possible. The influencing factors are the product — medical services; the consumer — the patient; the provider — the physician and his allies; the third party — government, industry, labor, health insurance carriers; the environment — where the service is rendered; and the economics — the cost of the service. Each is highly contributory; taken all together they develop a strong case for the necessity of utilization review.

Medical service, the product, is not a static commodity. Over the years such services have increased in quantity and quality with a resultant increase in unit and total cost. The challenge is how to make these services available to all at reasonable cost. How can this be done if we have no means of measuring normal use?

More and more the consumer assumes an important role. Formerly docile and easily led, he is now educated and sophisticated, particularly in medical matters. He realizes the benefits of quality medical care and its contribution to his well-being and longevity. He is aware now of the advances in medicine and earnestly desires the best in care for himself and his family. He is willing to pay a good share of his income to fill his needs, but if he can't afford it, he wants help to do so.

HOW CAN HE BE assured of quality?

How can he be assured of reasonable cost?

Only if we have the capacity to measure can we assure him. Only if we have the capacity to measure can we identify his needs and solve the problems of distribution of services, making this quality care available to him.

The physician and his team face a dilemma. In the face of an increasing population and increasing doctor to patient ratio, how is he to deliver the service? How is he to make available the better quality, the greater quantity of care to his patients? His predicament cannot be solved unless he has a way to measure the quality, to evaluate the cost versus the need. Utilization review would provide some of the information needed for such decisions.

The ultimate interests of all third parties are the same — getting the most and best care at the lowest possible cost per person. Their spheres of influence vary, occasionally overlap, but the objective is the same. And their interest cannot be maligned — their dedication to the task and desire for fulfillment equals that of the patient and the doctor.

Government seeks to assist by subsidization, but in protecting tax must have concern for quality and availability. Health insurance carriers aid by administering the techniques of prepayment and risk sharing, but have the same fiscal responsibilities and the same concerns toward members as government has for taxpayers. Industry and labor are equally concerned and pragmatic. Industry pays out large sums, negotiated by labor, to purchase medical care. As practical businessmen, managers want the best product at the best price. But how can this be determined unless we measure?

Doctor Hayes, formerly of Gaylord, is now vice president, medical affairs of Michigan Blue Shield in Detroit. This is one of a series of articles.

ENVIRONMENTAL FACTORS are significant in their impact. The location of the patient may influence the quantity and quality of medical service available; strangely enough there is deprivation in both congested urban areas and remote rural areas. Here is a need for measurement. Yet another need is the measurement of the efficiency of the site of the service — the hospital, the office, the home.

The final factor to consider is that of economics. All medical service has some cost; additionally, even the most naive will recognize that the total cost of medical service is rising and honesty compels us to recognize that the unit cost of care is also rising. Perhaps this trend cannot be stopped, but surely it can be reasonably controlled. *We* of health care to discover what is "reasonable." As a result we could maximize the efficiency of the delivery of medical services in all environments, thereby keeping cost to a minimum.

IS THERE ANY DOUBT of the need?

Everyone (the provider, the patient, the public) has the same concern, the same objective; each has his own interest, his own concerns; all have something to contribute in attaining the goal. Economic facts and the needs of all dictate the need for cost control; social and geographic facts dictate the need for quantity control. And, though there are other factors, the best interests of the patients, the pursuit of excellence and the professional pride on the part of the physician dictates quality control. He has proven his ability in the past, he can in this instance.

Measurement — utilization review — is the tool that can aid. ☐

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING JUNE 29, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	31	74	233	864
Whooping Cough	36	57	247	537
Diphtheria	0	0	0	0
Mumps	994	1,661	12,816	12,173
Scarlet Fever & Strep Sore Throat	491	646	6,596	8,942
Tetanus	0	1	2	2
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	181	119	1,059	1,050
Salmonellosis (Other than S. Typhi)	81	29	353	256
Typhoid Fever (S. Typhi)	0	0	0	4
Shigellosis	24	26	117	259
Aseptic Meningitis	2	10	26	19
Encephalitis	1	20	48	67
Meningococcic Meningitis	11	7	59	40
Influenzal Meningitis	5	2	31	23
Tuberculosis	214	180	1,425	1,482
Syphillis	326	401	2,784	2,993
Gonorrhea	1,215	1,317	8,280	8,226

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

ACTIVITIES, PROJECTS

PSYCHIATRY SOCIETY TO REPEAT COURSES

Beginning in September, the Michigan Society of Psychiatry and Neurology in conjunction with the Michigan Academy of General Practice again will offer its course in psychiatry for non-psychiatric physicians in several major cities around the state.

The nine-month course will end in May, 1969. It will be held on a given day of each month from 1:00 P.M. to 5:00 P.M.

This year the program will be open not only to physicians but also to psychologists, social workers, clergymen, nurses and other interested professionals. The program will emphasize principles and practice of psychological counselling and the management of emotional problems such as adolescents, marriage conflicts, hospitalized patients, psychosomatic and somopsychic disorders, neuroses, character disorders such as alcoholism, and some psychoses.

Physicians may obtain details from Leonard Rosenzweig, M.D., 515 Lakeside Drive, S.E., Grand Rapids, 49506. ☐

BOOK FIRM FOUNDATION HONORS EASTERN PROF

John Eager Howard, M.D., professor of medicine, Johns Hopkins University School of Medicine, received the Passano Foundation Award during the annual AMA meeting in San Francisco.

The Passano Foundation was established in 1945 to honor outstanding men of medical science in the United States. The Award of $5,000 is made yearly during the AMA convention. The Foundation is sustained by annual contributions from The Williams & Wilkins Company, a leading publisher of medical books and journals. ☐

MDPH Seeks Infants With Hearing Problems

Michigan physicians are being asked by the Michigan Department of Public Health to help identify and locate infants with profound hearing loss due to maternal rubella in early pregnancy.

According to a recent statistical projection made by the Department, 4,000 Michigan babies may have profound hearing loss resulting from the rubella epidemic which swept the country in the mid 60s, reaching a peak in Michigan during the years 1964-1966.

Theresa B. Haddy, M.D., Chief of the Division of Child Health at the Bureau of Maternal and Child Health, says that, "In the last year and a half over 400 infants with profound hearing loss have been identified. These range in age from 3 months to 3 years. A large proportion have positive histories of possible maternal rubella. This greatly increased incidence of profound hearing loss in early infancy suggests that Michigan babies were affected by the rubella epidemic."

"Early identification of hearing loss in infants is extremely important," she continues. "Carefully selected hearing aids and programs to stimulate the development of language and speech should be considered as early as possible."

"Local health departments," Doctor Haddy concludes, "or the Hearing and Speech Section of the Michigan Department of Public Health can assist with information regarding centers equipped and staffed to test the hearing of babies." ☐

STATE BIRTHS, DEATHS SHOW STEADY INCREASE

Both the number of births and deaths have increased in Michigan for 1967, as compared to 1966, according to provisional figures released by the Michigan Center for Health Statistics.

Comparing the two years, the causes of death have remained relatively the same — the big three of course being heart disease, cancer, and stroke, in that order.

There was a slight dip in the number of deaths due to accidents in 1967 as compared to 1966. ☐

	1966	1967
Births:	155,794	162,756
Deaths:	74,596	75,245
Causes of Death:		
1) Heart Disease	28,277	28,642
2) Cancer	12,506	12,999
3) Stroke	7,732	7,834
4) Accidents	4,737	4,470

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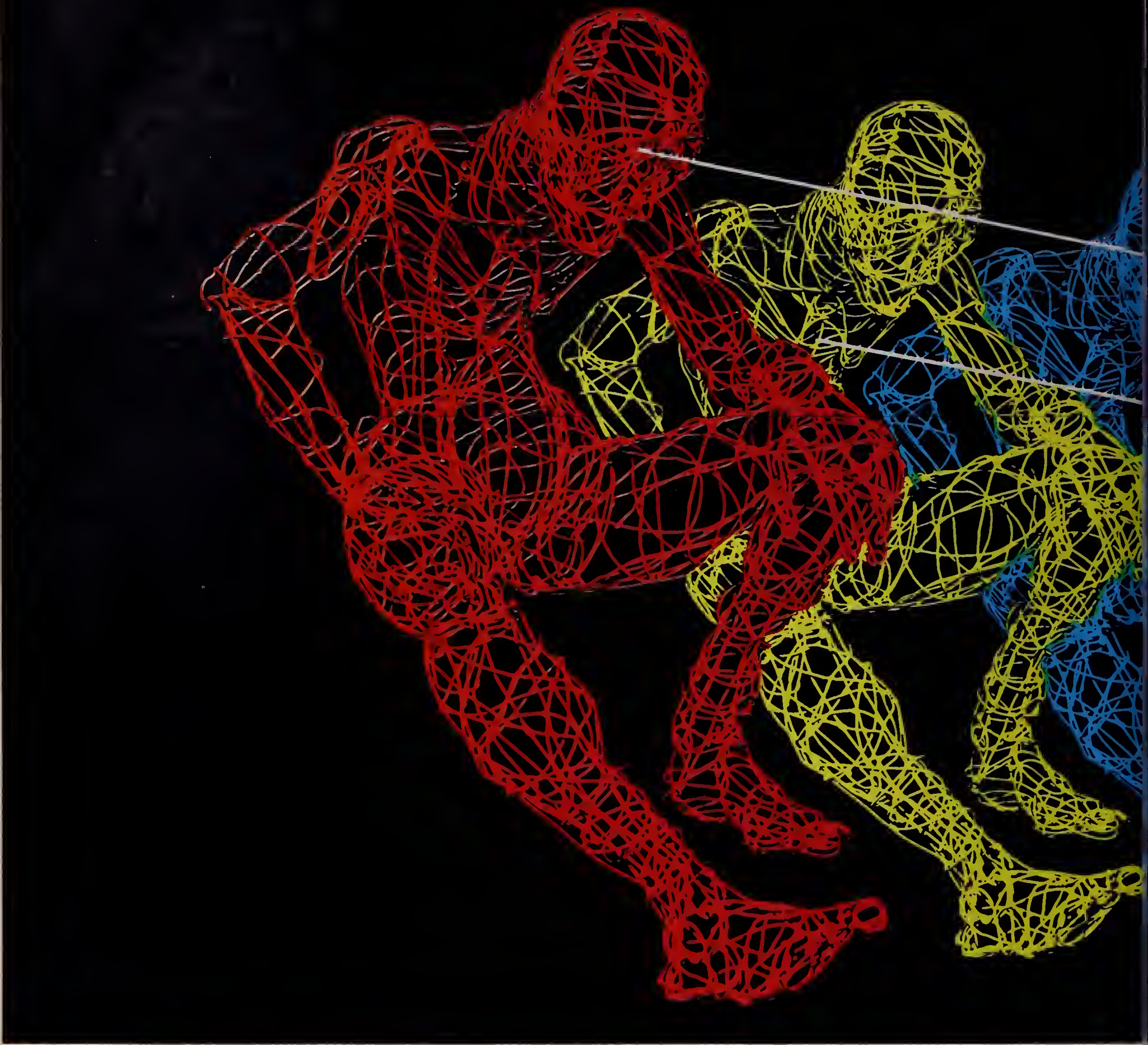

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Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
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Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

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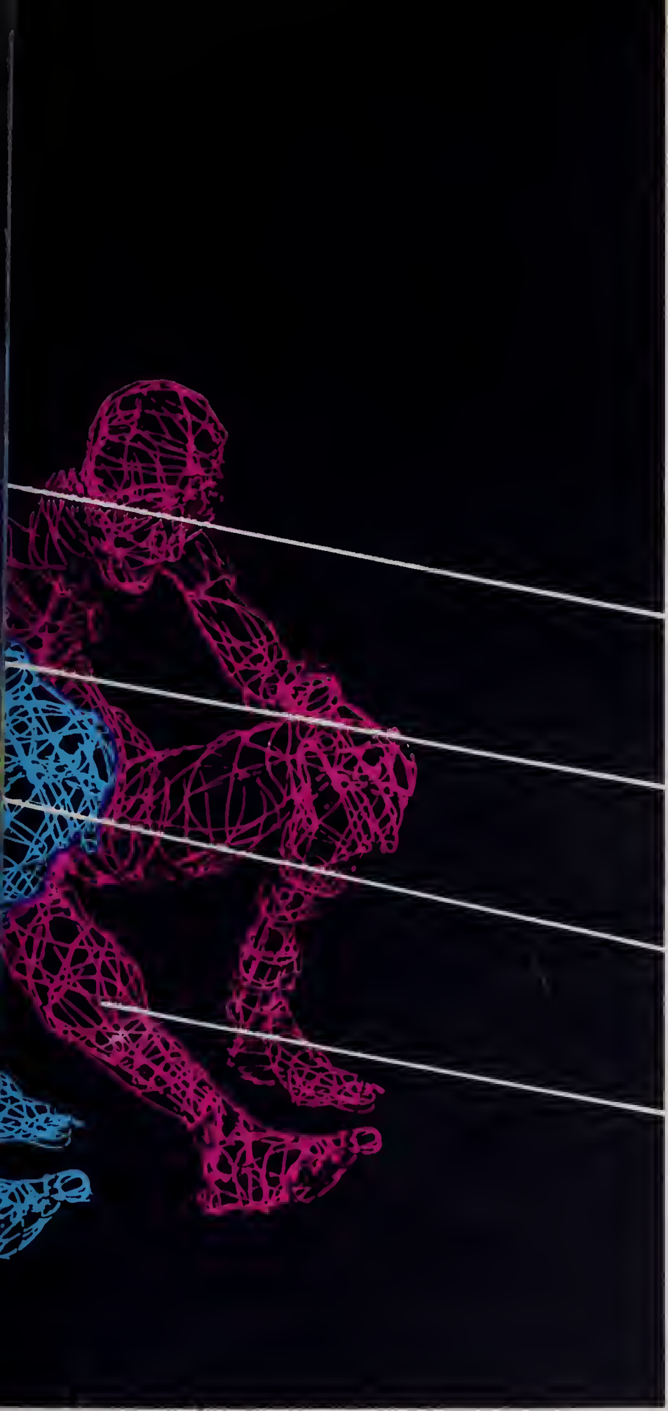

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Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

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Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

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5 mg

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Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

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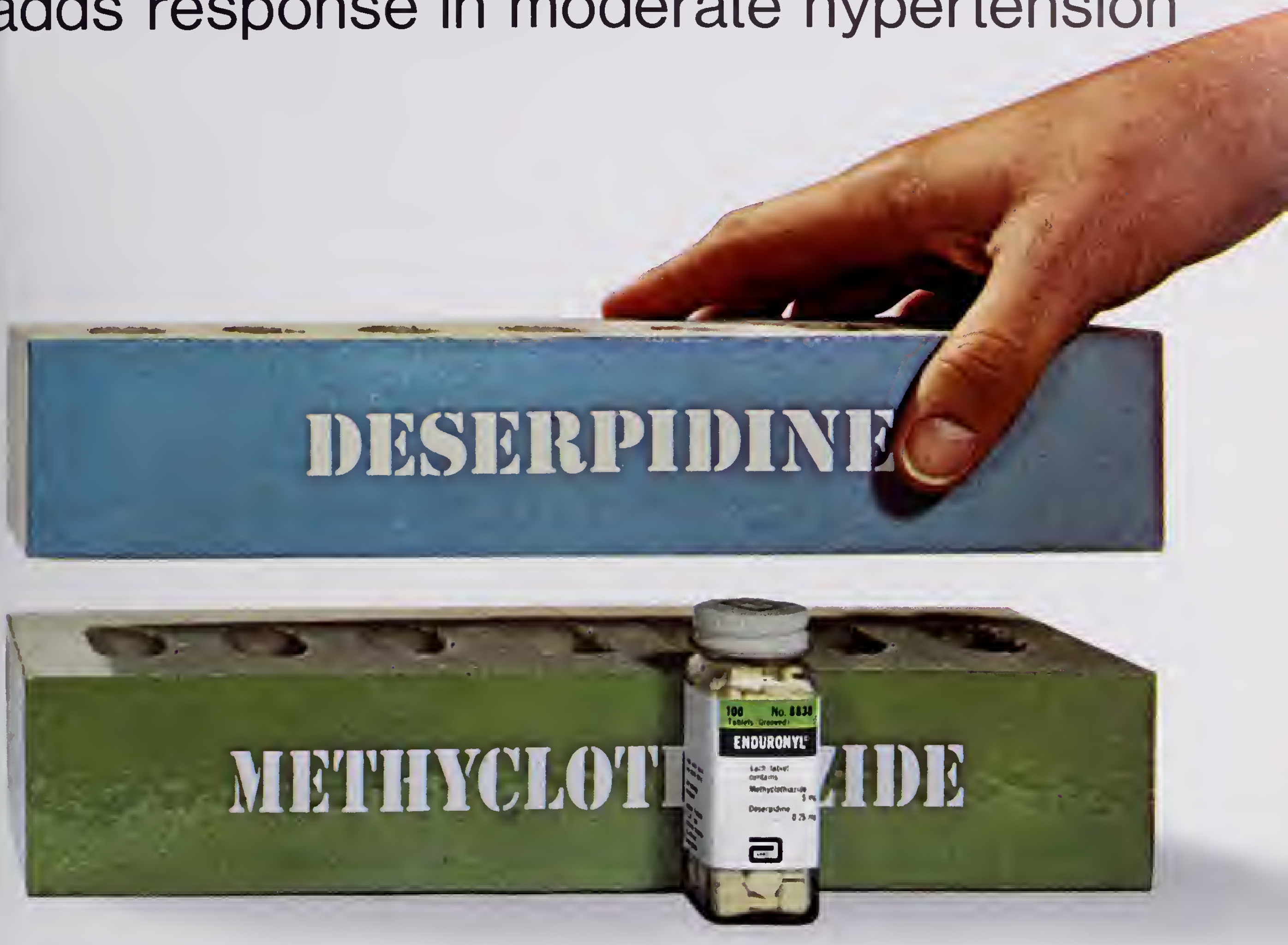
Enduronyl: Its deserpidine component adds response in moderate hypertension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Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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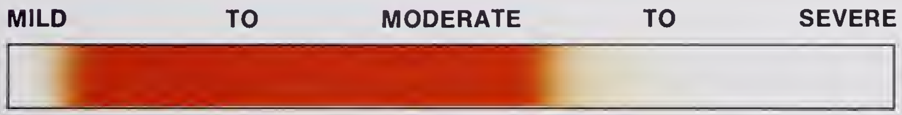
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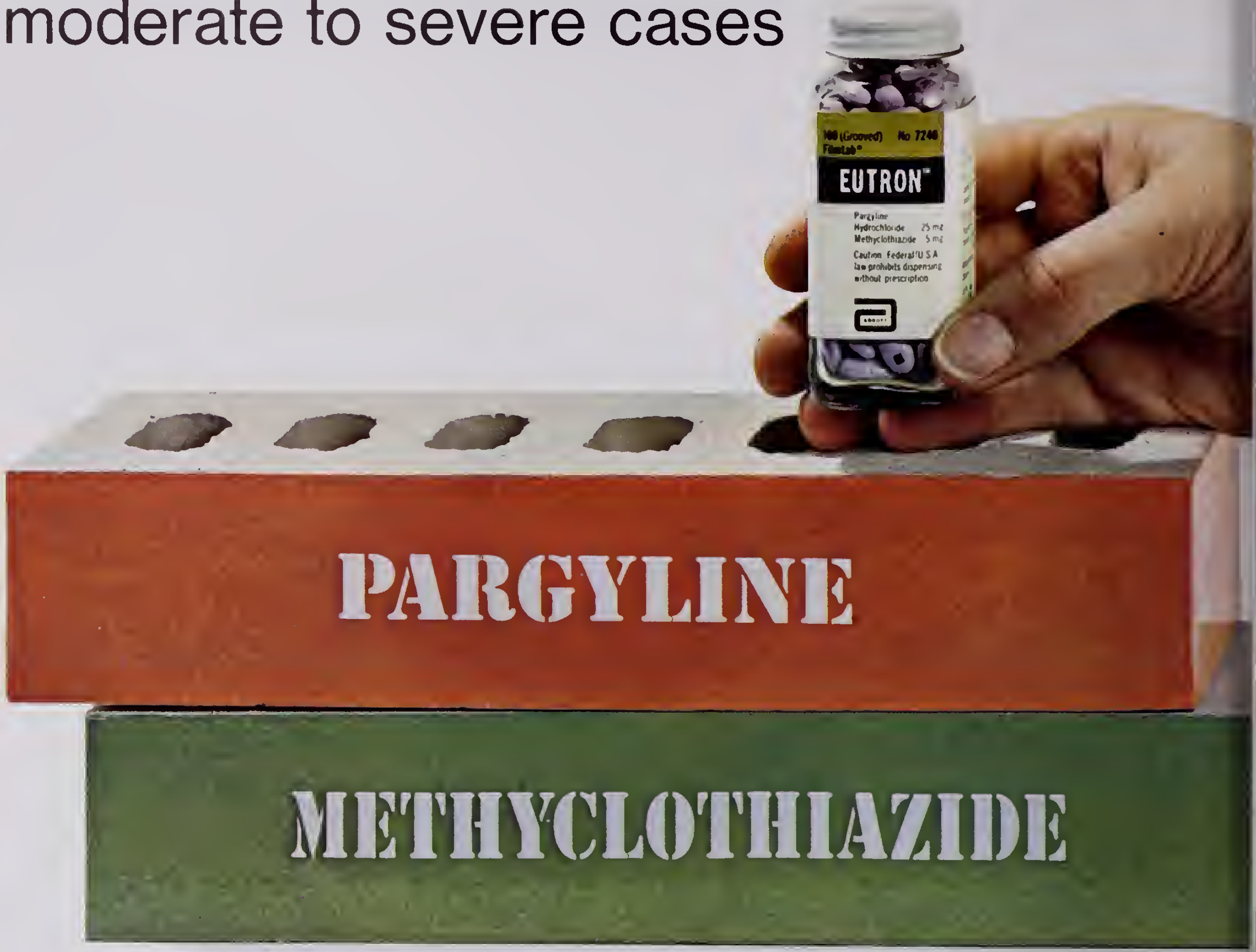
Eutron: A unique combination for handling moderate to severe cases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Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

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EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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State Supreme Court Rules MD Not Permitted To Testify in DO Suit

(Editor's Note: The following article is quoted from the AMA Citation newsletter of June 15, 1968, prepared by the AMA Law Department.)

In a patient's suit against an osteopath for injuries caused by his allegedly negligent performance of an oophorectomy, a trial court properly refused to permit an allopathic physician to testify as to the standards of osteopathic practice because the physician expressly denied having any knowledge as to the standards applicable to osteopathy. If he had knowledge of such standards, the Michigan Supreme Court said, he would have been qualified to testify. A new trial was ordered because of the trial court's refusal to allow the patient to call as an adverse witness a second osteopath, who had assisted in the operation.

The patient's right ureter was cut during the operation. The osteopath inserted a catheter in the opening of the ureter and closed the opening with sutures. The osteopath had intended leaving a Penrose drain in place over the urethral repair, but he overlooked doing so until the wound was completely closed. He decided not to reopen the abdomen, because he considered the urethral repair secure. When a systoscopic examination disclosed that the ureter's peristaltic action was expelling the catheter, the catheter was removed with forceps and a Foley catheter placed in the urinary bladder. A blockage of the ureter developed, which made another operation necessary.

During cross-examination on his qualification as an expert witness, the physician called by the patient stated that he knew nothing of the standards, procedures, and techniques of osteopaths. On redirect examination, he was asked if he was familiar with the standards of osteopaths in performing oophorectomies. The osteopath's objection to the question, based on the physician's prior admission that he was unfamiliar with osteopathic standards, was sustained. An offer of proof was made that the physician would have testified that the standards for performing oophorectomies were the same for physicians and osteopaths. Since the physician had stated, without qualification, on cross-examination that he was unfamiliar with

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osteopathic standards, he could not be permitted on redirect examination to contradict that testimony, even in part, in the face of the osteopath's timely objection. Thus, the sustaining of the objection was not reversible error.

However, the appellate court was incorrect in stating that the general rule prohibits opinion testimony from a medical practitioner solely because he is not a practitioner of the same school of medicine as the practitioner whose standards of practice are in issue. The Supreme Court said that, although there was language in some cases which suggested that such was the rule, it had never directly decided the specific question. The proper rule is that the standard of exclusion is not the school of the witness but his knowledge of the standards of the practitioner whose standards are in issue. In malpractice cases, the opinion testimony of a witness knowledgeable on the standards applicable to the profession of the practitioner against whom suit is brought and his compliance or noncompliance with those standards, is admissible, even though the witness does not practice the same profession or belong to the same school of healing as the practitioner against whom suit is brought.

In view of the physician's express disclaimer of knowledge of osteopathic standards, his testimony was not admissible under the "exception" referred to by the patient, which permits a witness of a school of medicine different from that of the practitioner against whom suit is brought to testify as to matters on which the principles of the two schools concur. — *Frazier* v. *Hurd*, 157 N.W.2d 249 (Mich., April 1, 1968) □

(Editor's Note: The decision of the appellate court was reported in THE CITATION, Vol. 15, No. 4, p. 58.)

USPHS TO STUDY HEALTH OF KENT COUNTY TEEN-AGERS

The U.S. Public Health Service will examine 200 Kent County young people, ages 12-17, during a three-week period beginning August 21, as part of a nationwide survey to ascertain the health of American teen-agers.

The health examinations, which will be conducted in the Survey's mobile center, are designed to collect data primarily on the health aspects of growth and development. The Survey is not intended as a screening procedure; referral for diagnosis is not made.

Parents of each youth examined are told that the examination is neither complete nor can be looked upon as a substitute for a visit to one's own physician and dentist, the Public Health Service explains. □

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Why MDPAC-AMPAC? What's It All About?

BY VERNON V. BASS, M.D.
CHAIRMAN, MDPAC
SAGINAW

Making laws is one of this nation's major activities. It keeps Congress busy for nearly eleven months out of twelve these days. Fifty state legislatures add thousands of laws more each year. Cities contribute a flood of ordinances to the total. The regulatory agencies crank out regulations in awesome numbers.

With the effect this entire process has on a business, an industry, a profession, a group of people, or the individual taxpaying citizen who must conform to the rulings of the legislative majority, it would seem logical to expect breathless attention to all these goings-on from every person of voting age in the United States. But as all of us know, it doesn't work out that way. Not one person in five is a political activist in the sense that he works for the political party of his choice, supports it financially to the degree that he is able, or turns a hand to the necessary work of helping a candidate win.

Until recent years, business, industry and the professions limited their activities to lobbying for specific legislative proposals.

THIS ATTITUDE IS CHANGING. Clearly, a loner in politics accomplishes little more than the casting of his single vote, important though that is. Just as clearly, a group of like-minded individuals can multiply their political effectiveness. Nothing prevents separate political groups like MDPAC from forming, on the basis of a shared point of view, and then working for a particular candidate as an auxiliary to his party organization during a three or four month campaign.

The new look in candidate support committees is different. They now function as parts of a permanent organization tied to neither party.

They are candidate oriented, but work for a selected candidate only during his campaign. They then sever the relationship until the next time the office is being contested and may, if they chose, decide at that time based upon the candidate's record, to support someone else.

These political hybrids are the new political action committees, of which MDPAC is one, and they are not only here to stay but constitute a force of growing power.

AUTONOMOUS POLITICAL action committees are now operating in each of the fifty states as well as in the District of Columbia, with members belonging to their State PAC and AMPAC as well.

Candidates are chosen by PAC members at the local level on the basis of political principles, chance to win, need for help, and several other factors. The PAC members within a Congressional District then set out to form a candidate support committee, raise money, and provide volunteer services for the candidate they choose.

If additional financial help is needed, the district candidate support committee applies to the State PAC. Political realism governs that decision.

Recognizing that able, intelligent candidates are to be found within the ranks of both political parties, MDPAC and AMPAC are resolutely bipartisan.

AMPAC is involved primarily in races for the

House, but has worked effectively in campaigns for the U.S. Senate.

The Michigan Doctors Political Action Committee is oriented to key congressional contests, but also involves itself in campaigns for the state legislators as well as other selected educational and judicial posts.

The American Medical Political Action Committee (AMPAC) was formed with the American Medical Association's official blessing as a voluntary, non-profit, unincorporated organization whose purpose was to help its members participate effectively in public affairs; further their political knowledge; and develop the means for concerted political knowledge; and develop the means for concerted political action.

AT THE NATIONAL LEVEL, AMPAC seeks to provide coordination, liaison and political training for its members. In terms of this training, a variety of political education programs is made available for use by MDPAC members. Courses in precinct action, films on politics, pamphlets on how to form political opinion, a membership periodical, exhibits are some of the materials AMPAC produces and disseminates. In essence, this sort of political education is comparable to the programming done by many of the public affairs departments of the nation's large corporations.

DOES THIS OVER-ALL approach work?

It does indeed.

AMPAC is now second only to labor in the total of its dollar support to Congressional candidates. And AMPAC's files are filled with testimonials from political candidates who believe that the margin between their defeat and victory at the polls was provided by the combined effort of physicians and their wives.

In these troubled days when Congress is called upon to consider a plethora of bills involving the nation's health medicine clearly has a gigantic stake in the election of intelligent men and women who will at least listen to the point of view of medical authorities before they make up their minds on proposed health legislation.

Medicine's PAC movement both at the national and state levels is helping to assure the election and re-election of such people, recognizing that legislative arguments minus candidate support often equal futility squared.

The MDPAC board is currently assessing the voting record of all legislators and will financially support on a bipartisan basis over fifty candidates for the 1969 legislature. Several members of the Michigan delegation to the Congress have likewise been recipients of MDPAC funds. Much more help is needed particularly by candidate support committees. MDPAC has doubled its membership in 1967. It is now approaching 30% of MSMS membership. This is due in part to billing procedures used in all counties except Wayne County.

MDPAC's EFFECTIVENESS could develop into a brilliant political success story. It needs your help to accomplish this, and in the 1968 election year a membership of at least a third of Michigan doctors is essential.

For twenty-five dollars ($25.00) become a member of both AMPAC and MDPAC. Mail your check to MDPAC, Box 169, East Lansing, Michigan 48823. Join the team! ☐

MSMS CONTINUES PAP TEST APPEAL

Daily and weekly newspapers throughout Michigan continued to carry the appeal of the MSMS Cancer Committee to Michigan women to have Pap tests.

Some of the headlines on the MSMS news release read:

Union Lake Spinal Column: "Cancer Check-ups Save Lives."

Detroit West Side Courier: "Urge Women Have Cancer 'Pap' Test."

Lansing State Journal: "Annual 'Pap' Test Needed."

Holly Herald-Advertiser: "Urge Women to Take 'Pap' Test."

Belleville Enterprise-Roman: "Physicians Advise Yearly 'Pap' Test to Spot Cancer."

Trenton Times: "Doctors Call Lack of 'Pap' Tests 'Tragic'."

TELLS GRADUATES EXPAND HORIZONS

Austin Smith, M.D., chairman of the board of Parke, Davis & Company, recently challenged the graduating seniors of the Massachusetts College of Pharmacy and Science to play a greater individual role in modern society.

Doctor Smith, who also received the college's 31st honorary degree, a "Doctor of Science in Pharmacy," urged students to expand their professional and personal horizons following graduation. "The greatest profession of all lies before you — the profession of living," he said. "The need to grow, to expand one's horizons, to realize that we cannot, as a professional person, or as a private individual, live in an isolated world, oblivious to outside influence or change.

IN MEMORIAM

F. J. Fitzpatrick, M.D., Pontiac

Francis J. Fitzpatrick, M.D., Pontiac internist for 41 years, died May 22. He was 70.

Doctor Fitzpatrick was a Life Member of MSMS and an honorary member of the staff at St. Joseph Mercy Hospital, Pontiac. He was graduated from the University of Michigan Medical School in 1924. He was a Diplomate of the Board of Internal Medicine and a member of Nu Sigma Nu medical fraternity.

W. E. McGillicuddy, M.D., Dearborn

Walter E. McGillicuddy, M.D., retired Dearborn otolaryngologist, died April 5 at the age of 86.

Doctor McGillicuddy, a 1913 graduate of the Detroit College of Medicine and Surgery, practiced pharmacy in Ontario and Detroit for a number of years. During World War I he served in the U.S. Army in France as an anesthetist. He formerly was on the staff of the Detroit Eye, Ear, Nose and Throat Hospital for eight years and was also affiliated with the Detroit T.B. Sanitarium.

He was an active member of the Masons and traveled extensively, visiting various hospitals in the interest of welfare work for Masonic organization. His hobbies were fishing and hunting and he was a member of the Paul Bunyon Conservation Club, French River Fishing Club, Canada Bon Ami Hunting Club and the Harmonie Society of the Canada Creek Ranch Association.

F. T. Reid, M.D., Birmingham

Fred T. Reid, M.D., Birmingham, died June 12 at the age of 71. Doctor Reid had practiced in the Detroit area since he received the M.D. degree from the University of Michigan Medical School in 1923.

His internship was at Grace Hospital, and he was a member of staff at Grace Hospital, St. Joseph's Mercy Hospital in Pontiac, and Ardmore Hospital in Ferndale. He served as a health officer at Clawson and received a 25-year service award as a Selective Service examiner.

He was a Life Member of MSMS, and had been a member of the Board of Directors of the Oakland County Medical Society.

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M. N. Southworth, M.D., Kalamazoo

Maynard N. Southworth, M.D., Kalamazoo general practitioner, died June 10 at the age of 62.

Doctor Southworth received the M.D. degree from the University of Michigan Medical School in 1930. He was affiliated with Borgess and Bronson hospitals in Kalamazoo and had served as a township health officer. From 1942 to 1946 he served in the Medical Corps. He was a member of the American Legion, the Elks Club and Theta Kappa Psi medical fraternity.

H. A. Sullivan, M.D., Detroit

Hugh A. Sullivan, M.D., surgeon at Harper Hospital, Detroit, for over 50 years, died June 1. He was 75.

Before his retirement, he was chief surgeon for the Department of Streets and Railways of Detroit for 42 years. He also served as a surgeon for the Detroit Police Department for 30 years.

He received his medical education at the Detroit College of Medicine, graduating in 1915. During World War I, he served on a surgical team headed by neuro-surgeon Harvey Cushing and later with Harper Hospital Base #17 in France.

Doctor Sullivan was a founding member of the American Board of Surgery and was a past president of the Detroit Academy of Surgery in 1942. He was a Life Member of MSMS and a member of the American College of Surgery and Phi Beta Pi.

G. C. Tornberg, M.D., Cadillac

Gordon C. Tornberg, M.D., Cadillac physician, died May 26 at the age of 55.

He had served as president and secretary of the Wexford-Missaukee County Medical Society and was an examiner for the Selective Service Board for 15 years. Active in community affairs, he was a member of the Chamber of Commerce, Rotary Club and Cadillac Club.

Doctor Tornberg practiced in Cadillac from 1940 until several years ago. He was a 1939 graduate of the University of Minnesota Medical School and also held a B.S. degree from the University of Michigan. His internship was served at St. Mary's Hospital, Duluth, Minnesota.

HPCM MOVES

The Health Planning Council of Michigan has moved from its present offices at 414 Hollister Building, Lansing to new quarters at 2213 East Grand River, Lansing, Michigan 48912. The telephone number, 482-5529, remains unchanged.

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Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.

* 1904 - 1967

A model of the Grand Rapids Public Museum area which will house a major new medical and health display is explained by Weldon D. Frankforter, right, museum director, to Charles Farber, M.D., left, president of the Kent County Medical Society; Frederick Brace, M.D., second from left, and James Muldoon, M.D., third from left.

Kent Doctors Provide Museum Health Display

A display of transparent human figures, fitted with tape-recorded "voices," will soon become a central part of a new major display at the Grand Rapids Public Museum thanks to a $25,000 grant from the Kent County Medical Society.

A complete "growth and development" series of displays will also be included to show the process of conception and birth.

"This will be a permanent medical exhibit showing the physical development of man," said Charles Farber, M.D., president of Kent County Medical Society. "We, the physicians of Grand Rapids, are taking the initial step in establishment of this exhibit, and it is our hope that the exhibit will be enlarged and extended to eventually include all fields of health."

Planning for the display, which will be a reality by the fall of 1969, has been done by a special committee of the Medical Society, headed by James Muldoon, M.D., of Grand Rapids and working closely with Weldon D. Frankforter, Museum Director. Also active on the committee is Fred Brace, M.D., of Grand Rapids. ☐

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

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vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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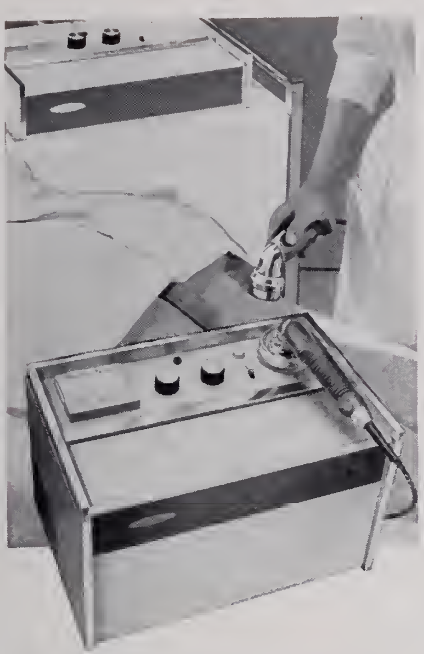

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MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Michigan
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Edward F. Knoschnabel, M.D., Marquette, is aboard the S.S. Hope on its second rotation in Ceylon from June 13 through August 15. He is the only otolaryngologist on the staff.

Joseph A. Witter, M.D., Highland Park, was honored by the medical staff of the Highland Park General Hospital at the annual dinner for his activities as chief of surgery at the Highland Park hospital from 1956 to 1968.

Michael S. Leahy, M.D., Ann Arbor, has been selected the outstanding resident of the year at the University Hospital. For his outstanding work as the senior resident in pathology, he will receive an honorarium and a certificate of achievement.

Paul T. Lahti, M.D., Royal Oak, and his associates were pleased to find in a recent article in *Time* quotations from Doctor Lahti's article "Early Postoperative Discharge of Patients from the Hospital," published in *Surgery,* March 1968.

David Hills, M.D., St. Joseph, has been named to head a committee to unify health planning in the St. Joseph-Benton Harbor area on a long-range basis.

Frederick J. Chapin, M.D., Bay City, immediate past president of the Bay, Arenac, Iosco Counties Medical Society, surprised members of the county society with his announcement that he would be leaving the pediatrics practice he has had there for 23 years. He will train in and practice psychiatry in Traverse City.

Michael J. Brennan, M.D., Detroit, has been named to the National Advisory Council on Regional Medical Programs of the National Institutes of Health. The Advisory Council assists in policy matters and in the preparation of regulations and also makes recommendations on grants.

Louis Carbone, M.D., Detroit, was saluted as a "physician to mankind, friend to St. John Hospital and contributor to his community" when he received the "Man of the Year" award of St. John Hospital, Detroit.

William H. Beierwaltes, M.D., Ann Arbor, told the Society for Nuclear Medicine recently in St. Louis that three cancer patients at the U-M Hospital have received a new diagnostic drug which apparently has revealed the extent of malignant melanotic tumors for the first time. The drug, NM-113, he said, is structured like chloroquine and contains a radioactive atom which quickly reveals its presence to photo-scanning instruments.

Harold F. Raynor, M.D., Detroit, recently received a Golden Anniversary Diploma from the WSU Alumni Association in recognition of his 50 years in medicine. Although retired from private practice since 1957, Dr. Raynor continues to work as associate medical director at the American Red Cross, Elizabeth Street, Detroit, and as a physician for the Highland Park Fire Department.

Sol C. Grossman, M.D., Huntington Woods, has been elected president of the Michigan Psychoanalytic Society for 1968-69. Other officers chosen are: vice-president, Saul Harrison, M.D.; secretary, Ira Miller, M.D., Ann Arbor; treasurer, Jack Dorman, M.D., Detroit.

Paul L. Lowinger, M.D., Detroit, spoke at Oxford, England, at the meeting of the Medical Association for Prevention of War. His topic was "Hospitals, Doctors, and Riots."

Fred W. Whitehouse, M.D., Detroit, is the newly-elected president of the Michigan Diabetes Association. He is Chief of the Metabolism Department of Henry Ford Hospital, Detroit.

Samuel J. Nichamin, M.D., Southfield, is the author of an article "Atypical Manifestations of the Recurrent Pleurodynia Syndrome in Children and Adolescents" in the April 1968 issue of *Clinical Pediatrics.*

Frederick C. Swartz, M.D., Lansing, chairman of the AMA Committee on Aging, was a featured speaker at a special half-day session on automated multiphasic screening programs during the recent AMA Annual Convention in San Francisco.

VOLUME 67, NUMBER 16 ● AUGUST 1968 ● DEADLINE FOR COPY, AUGUST 26, 1968

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

Annual Session, September 25-26 Offers Both Depth and Variety of Subjects

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"Our program this year," says Alexander J. Walt, M.D., chairman of the MSMS Annual Scientific Session program committee, "is designed for maximum impact to serve the needs of the practicing physician in the shortest space of time."

"We have shaped the program so that it provides both depth and variety in conveying the newest developments in scientific medicine to the practicing physician," Doctor Walt continued, in commenting on the over-all thrust of this year's September 25-26 meeting at the Sheraton-Cadillac Hotel in Detroit.

"There are several main features which I think will be of great interest to physicians," Doctor Walt said.

"FIRST, THE MSMS Annual Scientific Session is a concentrated two-day meeting," he continued.

"Through our new all-day postgraduate courses guest faculties will give in depth treatment to several important topics stressing the clinical and patient-care aspects. On Wednesday, September 25 we are offering all-day postgraduate courses on Infectious Diseases and on Pulmonary Diseases," he said. "On Thursday we will focus on Blood Diseases and on Difficult Decisions in Digestive Diseases."

"These postgraduate courses," Doctor Walt said, "will be on a limited enrollment basis only and I would encourage doctors to register for them as early as possible. We want to provide an intensive, seminar atmosphere so that the physician participant can get the maximum individual attention."

"SECONDLY, WE ARE having two large general sessions from 9:00 a.m. to noon on the important topics of Breast Carcinoma (Wednesday) and Heart Disease (Thursday)," Doctor Walt commented.

"In addition, there will be concomitant sessions on current problems in a wide variety of disciplines."

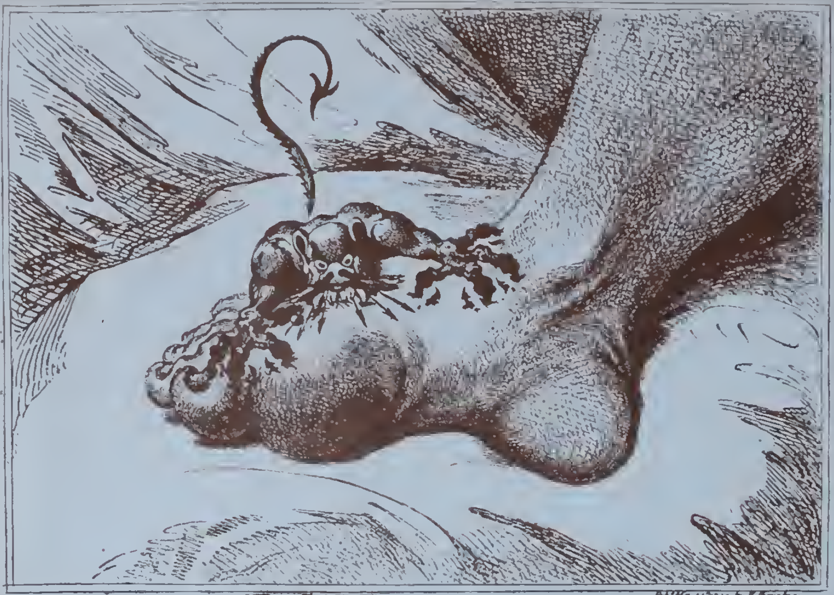
"THIRD, I WOULD like to draw the attention of physicians to the two outstanding luncheon speakers at the Annual Session," Doctor Walt added. "On Wednesday, Harry F. Dowling, M.D., of Chicago, will speak on 'Drugs, Doctors and Government.'

"On Thursday, David Hume, M.D., from the Medical College of Virginia, will speak on 'Organ Transplantations.'

"FINALLY, I THINK our Thursday afternoon General Session on 'What's New in the Practice Of' will be of special value to physicians.

"In conclusion, therefore, I think our program will be of high value for these reasons," Doctor Walt said. "Gathered for an intense two day session will be local, national and international medical authorities.

"THE PRACTICING PHYSICIAN can choose from the program according to his own needs: he can choose in depth study of a particular field or he can choose to learn the newest developments in fast-paced sessions which will cover a variety of topics."



The GOUT

"Ars Medica" Exhibit Coming To Detroit in September

MSMS members and wives are especially invited to view the **Ars Medica** exhibit of prints at the Detroit Institute of Arts during the MSMS Annual Session in Detroit, September 22-26. The special exhibit of prints depicting medical subjects is being brought to the Detroit Institute, for September 22 through October 20 through the joint efforts of the Institute and a special committee of Detroit area physicians.

The above colored etching entitled **The Gout,** was done in 1799 by James Gillray, of England, who lived from 1757 to 1815. More than 130 original works, obtained from the Philadelphia Museum of Art and purchased through special funds from Smith Kline & French Laboratories, includes woodcuts, engravings, eachings, lithographs, and serigraphs.

COMPLETES DETROIT SMOKING RESEARCH

Children exposed to tobacco smoke have twice as many respiratory diseases as do children in nonsmoking families, according to a recent health survey of 727 Detroit families, conducted by Paul D. Cameron, Ph.D., assistant professor of psychology at Wayne State University.

The study also disclosed that the more smoke children were exposed to, the greater their chances of being ill.

Bruce Leaves WSU To Join Oklahoma

Thomas A. Bruce, M.D., Professor of Medicine and Assistant Dean at the WSU School of Medicine, has resigned to become Professor of Medicine and Head of Cardiology in the Cardiovascular Division of the University of Oklahoma School of Medicine at Oklahoma City. A member of the WSU staff since 1961, he was appointed Assistant Dean in 1966. He earned his M.D. degree at the University of Arkansas.

MSMS, MNA Pla Nurse-Physician Confab, Soon

Twenty-five selected physician and 25 selected nurses will mee for an invitation-only "Conferenc on Strengthening Nurse-Physicia Relationships" September 4-5 a the MEA Conference Center at St Mary's Lake near Battle Creek.

Robert L. Tupper, M.D., chairman of the MSMS Committee or Nursing, will preside at an addres given by Floyd Mann, Ph.D., fron the Center for Research on Utilization of Scientific Knowledge, University of Michigan, on "The Effect of Nurse-Physician Relationships on Patient Care," on Wednesday evening September 4.

Participating in a discussion Sept. 5 on "The Changing Scope of Medical and Nursing Practice" will be a nurse and Glenn E. Moore, M.D., surgeon and vice-chief of the trauma section, Hurley Hospital, Flint. "Preparation for Changing Practice," will be discussed by Harold F. Falls, M.D., professor in the department of ophthalmology at the University of Michigan Medical School, and a nurse. "Merging and Emerging Areas of Practice" will be examined by Doctor Tupper and a nursing professor.

A special panel of members of the MSMS Committee on Nursing will discuss the final topic, "Colleagues in Collaboration—Toward Improved Patient Care." Panel members will be Shirley Austin, M.D., Gwendoline MacDonald, R.N., EdD, Dirk R. Mouw, M.D., and Theresa Phelph, R.N., Robert L. Tupper, M.D., will moderate the group.

MDPAC BREAKFAST
SEPT. 25, DETROIT
DURING ANNUAL SESSION

Wayne Professor Berman Dies

Lawrence Berman, M.D., professor of hematopathology at the Wayne State University School of Medicine, died of a heart attack on July 8. He was a co-founder of the American Society of Hematology and achieved wide recognition for research in cancer, leukemia, cell culture and biology. He was an associate editor of *Survey of Pathology in Medicine and Surgery*.

Doctor Berman received his M.D. degree from the University of Minnesota. He joined the medical faculty at Wayne State University in 1941 and served as chairman of the department of pathology from 1961 to 1964. He served as consultant to several Detroit area hospitals, including Detroit General, Detroit Memorial, Wayne County General, Oakwood, Sinai, St. Joseph Mercy in Pontiac, and the Veterans Administration Hospital in Allen Park.

OFFICE MANAGEMENT SEMINAR

MSMS will present an Office Management Seminar during the Annual Session for new physicians, residents, interns, and senior medical students from 3 to 5:30 p.m., Thursday, September 26 at the Sheraton-Cadillac.

A grant from Merck Sharp and Dohme makes this new feature possible.

INDEX MEDICUS AVAILABLE AT MSMS

Index Medicus, a monthly bibliography listing all articles contained in over 1300 world-wide medical publications, is now available at MSMS headquarters.

The MSMS collection dates from January 1968 to the present.

Physicians who need information from this handy publication of the National Library of Medicine should write or phone MSMS headquarters in East Lansing.

Seeks to Promote Medical Examiner System for State

To MSMS Members:

The Legal Affairs Committee of the Michigan State Medical Society has studied the possibility of a Medical Examiner System for Michigan for several years, and has supported several bills in the legislature which would extend and improve the existing county medical examiner system. (It is apparent that development of a central state-wide medical examiner system will require the support of the medical profession generally.) This is, therefore, a search for interested physicians. Any physician who is willing to give moral support now, or to consider active community service as medico-legal investigator in his own locale in support of a central state-wide system should correspond with

MEDEX, 120 W. Saginaw,
E. Lansing

An expression of opinion as to appropriate remuneration for participating physicians would be helpful.

R. C. Hendrix, MD
Chairman, Special Study Group
on Medical Examiner Laws

Medically Indigent In Homes Eligible For MD Services

R. Bernard Houston, Director, Michigan Department of Social Services recently announced that physicians' services may now be provided to group 2 (medically indigent) in the Title 19 (Medicaid) program who are receiving nursing home services in approved nursing homes, hospitals with chronic units rendering long-term care and county medical care facilities.

Physicians' services provided after July 1, 1968 will be covered to the extent of the first $50.00 or that portion of the first $50.00 not covered by Medicare (Title 18B) plus 20% of the remainder of the expense each calendar year. Physicians will bill the Michigan Medical Service for services on the same forms and in the same manner as for other services to eligible recipients.

There is no change in the physicians' services benefit for group 1 (categorical needy) recipients and patients are allowed freedom of choice of physician.

The Michigan Health Careers Mobile is making the county fair circuit to tell young people and their parents more about the many possibilities for careers in medicine and health. Among the active workers during the visit to the Vassar Fair were, left to right, Maurice H. Chapin, M.D., Millington, former county society president; Kathy Burns, student nurse; Mrs. Jack E. Goodwin, Auxiliary state chairman, Health Careers Committee; and Edward Elmendorf, M.D., current president of the Tuscola County Medical Society.

MSMS One Day Scientific Courses
September 25 & 26, Sheraton-Cadillac Hotel, Detroit

Enrollment Request:
Check course desired

Two courses to run simultaneously each day from 8:45 a.m. to 5:00 p.m.
Registration is limited to the first 45 persons enrolling in each course.
Course fee: $10 per course

Wednesday, September 25 (check one)

1. **Infectious Diseases** ______
2. **Pulmonary Diseases** ______

Thursday, September 26 (check one)

1. **Blood Diseases** ______
2. **Difficult Decisions in Digestive Diseases** ______

Name ____________________

Address ____________________

Check Enclosed ____________________

Clip and Mail to MSMS, Box 152, East Lansing 48823

Course Content

Infectious Diseases

Chairman: A. Martin Lerner, MD

Recent advances in diagnosis, prevention, and therapy of bacterial and virus diseases will be discussed. Topics include respiratory virus, measles, and mumps vaccines; rubella; antiviral chemotherapy; interferon and new antibiotics with their special toxicities.

Pulmonary Diseases

Chairman: Geoffrey L. Brinkman, MD

The Pulmonary Course will cover management of respiratory failure, beginning with a discussion of the clinical manifestations and physiological abnormalities, and the best methods of care and rehabilitation. Speakers also will discuss pulmonary embolsis and advances in radiological techniques, medical therapy and surgical prevention and cure; and also acid-fast infections.

Blood Diseases

Chairman: Arnold R. Axelrod, MD

The postgraduate course in hematology is designed to orient the practicing physician to some of the common hematological problems manifested by changes in the peripheral blood cells. Our purpose is to develop an approach to the proper diagnosis and management of these entities.

Difficult Decisions in Digestive Diseases

Chairman: William S. Haubrich, MD

Practical problems encountered in gastroenterology, of concern to both the physician and the surgeon, will be explored by the case method. Each of six well-known MSMS members, active in the practice of gastroenterology, has selected and will present a case from their own files vividly illustrating particular problems in diagnosis and management. Doctors enrolled for the course will participate actively with invited guest experts in seeking answers to the questions raised. Controversy is expected, profitable discussion is assured.

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY
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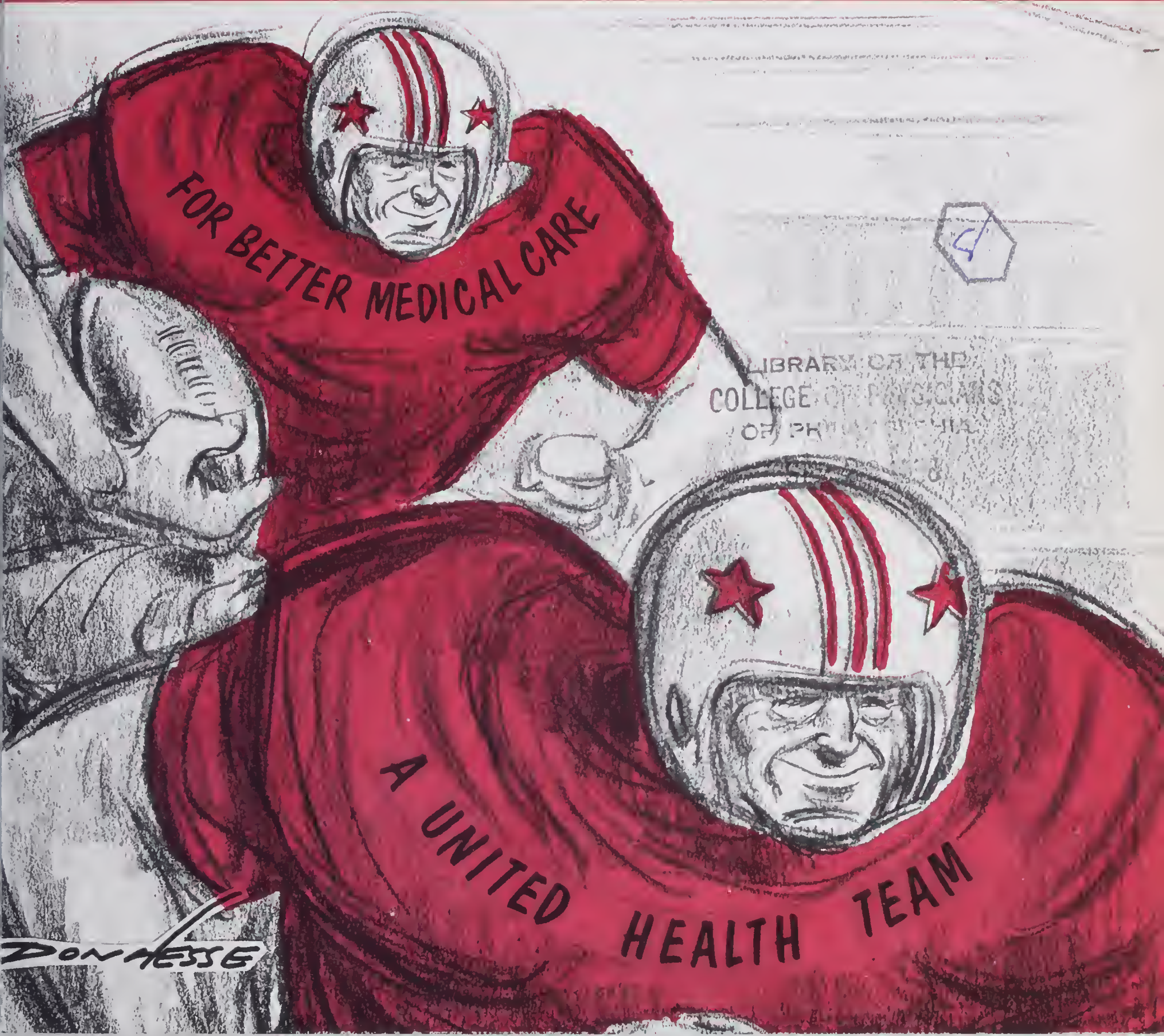
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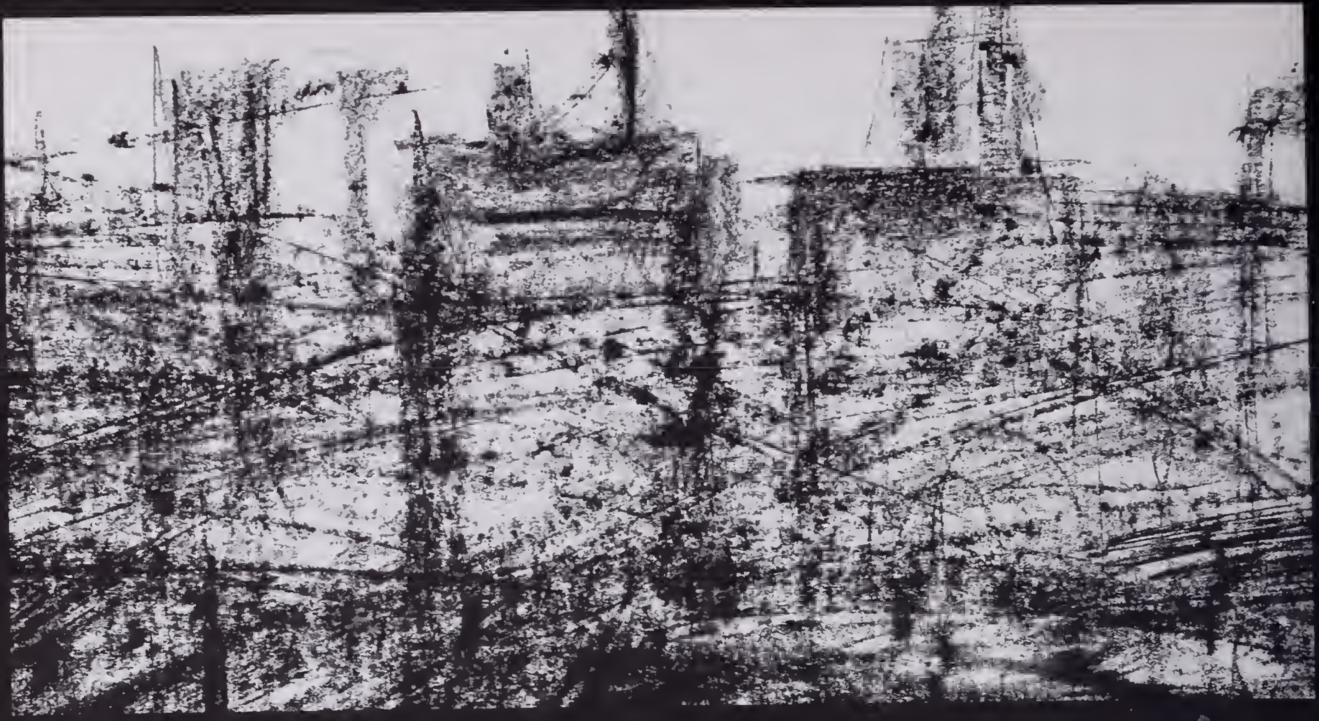
MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 17
SEPTEMBER 1968

BLOCK OUT YOUR CALENDAR NOW:

Sept. 22-24 — MSMS House of Delegates
Sept. 25-26 — MSMS Annual Scientific Session
Sept. 24-26 — Woman's Auxiliary to MSMS
Sept. 25-26 — Michigan State Medical Assistants Society
Sept. 22-Oct. 20 — "Ars Medica Art Exhibit"



1968 MSMS ANNUAL SESSION SEPTEMBER 25-26 DETROIT

PG Refresher

No Registration Fee

The Calendar for the Two-Day Scientific Session At the Sheraton-Cadillac Includes:

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Four All-Day Courses

Two General Luncheons with Speakers on "Drugs, Doctors, Government" and "Organ Transplantation"

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Many MSMS Section Programs

Medical Specialty Society Events

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Office Management Seminar

MSMS Party

"Ars Medica Art Exhibit"

Educational Exhibits

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MICHIGAN MEDICINE

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SEPTEMBER, 1968 • VOLUME 67 • NUMBER 17

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1063 Evaluation of a Screening-Technique for Urinary Tract Infections In Diabetic Out-Patients; Ali Abbasi, M.D., Lawrence Power, M.D.

1066 The Treatment of Trigeminal Neuralgia And Other Facial Pain with Carbamazepine; K. I. Kiluk, M.D., R. S. Knighton, M.D., J. D. Newman, M.D.

1070 Acute Myocardial Infarction Preceding Diabetes Mellitus; Marjorie Peebles-Meyers, M.D.

1071 Faulty Neurologic Integration With Perceptual Disorders in Children: An Abridged Treatment Approach; A Two-Dimensional Program of Methylphenidate and Psychologic Management; Samuel J. Nichamin, M.D., George D. Barahal, Ph.D.

1076 Marked Eosinophilic Response to Combined Chlorpromazine and Trifluoperazine Therapy; Melvin J. Reinhart, M.D., Martha Stephens, M.D.

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THE COVER

This month the cover recognizes the beginning of football season to call attention to the need for teamwork during the 1968 Community Health Week in October. The cover cartoon was made available by the AMA Communications Department. See Page 1083 for CHW details.

OFFICIAL PUBLICATION • MICHIGAN STATE MEDICAL SOCIETY

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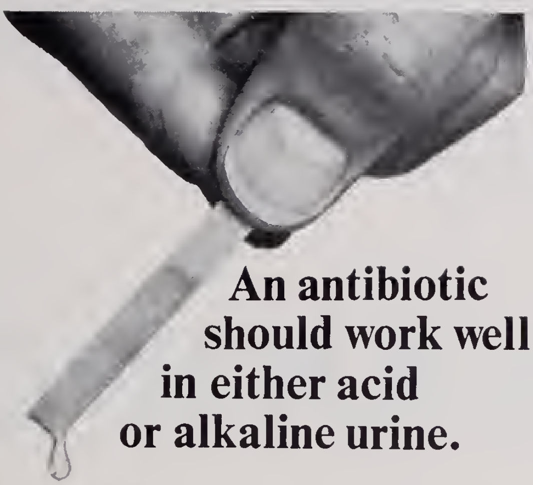

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Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

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STOP LEARNING

No, the medical profession can never stop learning. Recently the Coggeshall Report declared, "Rapid growth of knowledge and the introduction of new techniques make skills obsolete and comprehension inadequate long before the active professional life of the practitioner is finished. Thus, he can at no time be considered a finished product."

A recent editorial in JAMA discussed the continuing education efforts of state medical societies and declared that such programming, "demonstrates the leadership in maintaining professional competency can be assumed by the profession itself . . . and that is exactly where it belongs."

1968 MSMS Annual Session
September 25-26, 1968
Sheraton-Cadillac Hotel
Detroit

BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Thank you . . .

With deep gratitude, I want to thank you for the opportunity to serve as President of this outstanding Michigan State Medical Society this past year.

Many of our major efforts this year will be continued effectively this coming year by MSMS under the excellent leadership of Jim Lightbody.

Considerable time and effort has been spent during 1967-1968 in the areas of continuing education, legislation, federal medical programs, medical manpower, and communications. In its more than 100 years of service to the public and the medical profession, MSMS has a fine record of performance in this complex field and many others. The House of Delegates, The Council, and our committees have acted wisely to establish realistic policies and to implement vital programs. New guidelines, I am sure, will be considered this month by the 1968 House of Delegates.

The State Society, the county medical societies, and every physician must become better informed about the many federal medical programs. These will continue to demand our attention so the medical profession can help them work effectively and economically to serve those who may need special medical services.

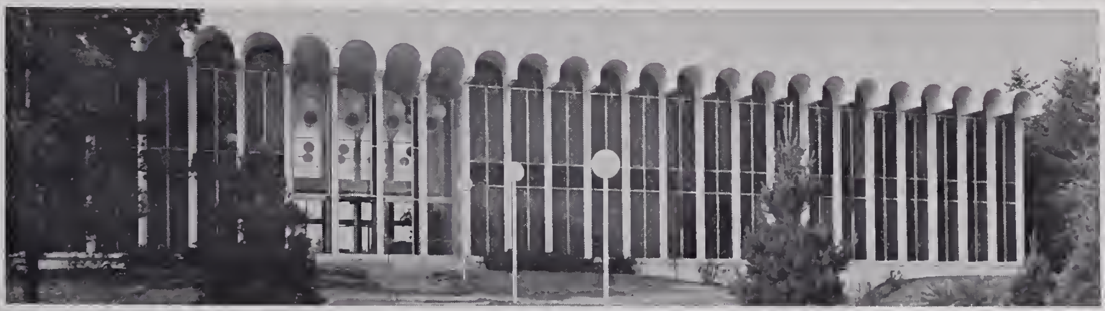
Medical legislation is closely related to the federal programming and I am pleased to see more and more county medical societies improving liaison with their state legislators and national congressmen. MDPAC has made tremendous strides forward this past year.

It seems hardly necessary to challenge each physician to become even more concerned about good communications, strong medical career recruitment efforts, and meaningful postgraduate educational projects. In all these fields, MSMS has strong committees providing solid direction — and staff members that are skilled, creative, and energetic. MSMS has a very good staff of dedicated men and women, and I offer my sincere thank you to each of them for guidance and encouragement given to me this past year.

MSMS has gained considerable stature during the past several years at the meetings of the AMA House of Delegates. Michigan delegates continue to offer timely resolutions, to serve effectively on various reference committees, and to debate the issues with statesmanship.

As a MSMS representative this year, I was well received at meetings of county medical societies, nearby state medical societies, the Upper Peninsula Medical association, AMA functions, and activities of many medical and health-related organizations.

I pledge my support to future MSMS leaders so together we can build an even more effective state medical society to serve the public and the medical profession.



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Tandearil® in Osteoarthritis
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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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ıte a latent peptic ulcer. The patient should
e instructed to take doses immediately after
eals or with milk to minimize gastric upset.
rug rash occasionally occurs. If it does,
omptly discontinue the drug. Agranulocy-
sis, exfoliative dermatitis, Stevens-Johnson
ndrome, Lyell's syndrome (toxic necrotiz-
g epidermolysis) or a generalized allergic
action similar to a serum sickness syn-
ome may occur and require permanent
ithdrawal of medication. Agranulocytosis
an occur suddenly in spite of regular, re-
eated normal white counts. Stomatitis, sali-
ary gland enlargement, vomiting, vertigo and
nguor may occur. Leukemia and leukemoid
actions have been reported. While not defi-
tely attributable to the drug, a causal rela-
onship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

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Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response.
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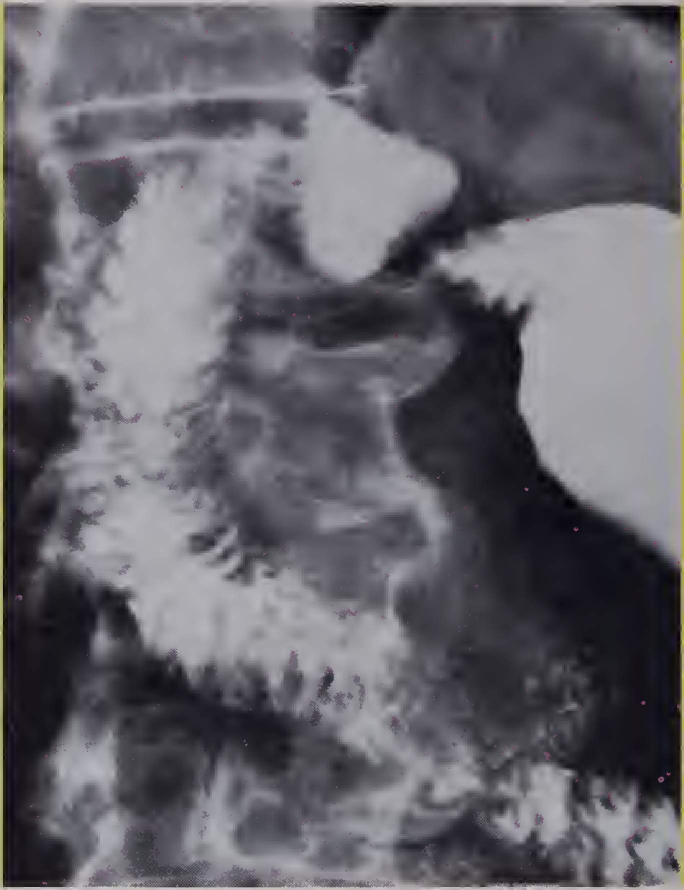

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How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthīne. The duodenum was intubated. Pro-Banthīne in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis, and double-contrast visualization was achieved with ordinary barium and air.

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...AT REST

SAME DUODENUM—(Hypotonic X-ray) Pro-Banthīne-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

Contraindications: Glaucoma; severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. *50*:445-460 (May-June) 1955.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

LeRoi J. Alexander, M.D., 5003 N. Saginaw Street, Flint, 48505

Carlos J. Bulcourf, M.D., 31170 Hoover Road, Warren, 48093

Manuel M. Campos, M.D., 72 Sheldon Ave., S.E., Grand Rapids, 49502

Allen J. Enelow, M.D., 936 Southlawn, East Lansing, 48823

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Charles G. Mendelson, M.D., Henry Ford Hospital, Detroit, 48202

Benjamin A. Passos, M.D., 304 N. Cochran Ave., Charlotte, 48813

Om Prakash, M.D., 1023 William Street, Lansing, 48915

Gerard Scott, M.D., 5670 Dixie Highway, Saginaw, 48601

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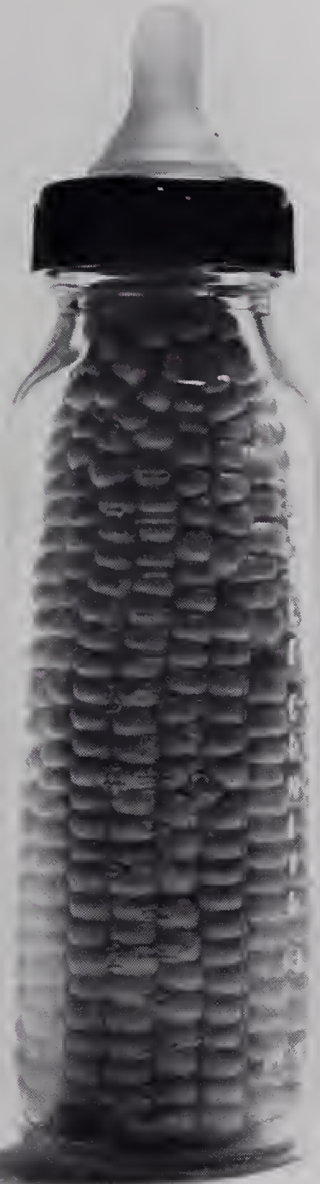

Just enough to eliminate unnecessary ingredients and provide excellent nutritive value. Both corn oil and corn syrup solids are used in Modilac,™ Gerber Baby Formula to provide essential nutrients with allergenic potential from only a single additional protein source. Corn oil replaces butter fats, supplying generous levels of the essential linoleic acid. Corn syrup solids provide dextrose, maltose and dextrins for spaced carbohydrate absorption. All of these components come from the single ingredient—corn, thus minimizing the possibility of allergy arising from a variety of ingredients.

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[1] J. Nutrition 66:555-565, 1958.
[2] Acta Paediatrica, Suppl. 137, 1962.
[3] Jrl. of Pediatrics 64:666-682, 1964
[4] Pediat. Clinic N. Amer. 12:309-335, 1965.

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VIEWPOINTS

House Reference Hearings Are Open

BY JAMES B. BLODGETT, M.D.
MSMS SPEAKER

The September meeting of the MSMS House of Delegates is the first regular meeting at which I shall preside as your newly-elected Speaker. I am grateful for this honor and mindful of the responsibility that this privilege implies.

The Annual Meeting of the elected Delegates is the means by which MSMS policy is determined and implemented. Each seated Delegate represents 50 physicians from his district.

IT IS THE BUSINESS of the House to consider committee actions and recommendations from the previous year and act upon resolutions which are presented to it by its members. These matters are first referred to Delegates Reference Committees composed of a number of Delegates. At the hearing of these committees the questions are studied in depth by consideration of pertinent data and by discussion with interested Delegates and members.

> *The reference committee meetings are held at a time when the House is not meeting and are open to any interested persons. The recommendations of the Reference Committees are then reported to the House where they are further discussed and considered by the full membership. Only then is action taken which may approve, disapprove or study further the questions at hand.*

In addition to these deliberations, the House directs policy through its various elections. The House elects Delegates to the National House of Delegates of the AMA; members of The MSMS Council who provide the continued direction of MSMS between sessions of the House; physician representatives on the Board of Blue Shield; members of the Judicial Commission; and finally the officers of the State Society including the Speaker.

IT IS IN THIS manner that your Delegates exercise a direction of the Society in making policy and its implementation. As Speaker, it is my duty to see that this democratic process is fairly and efficiently carried out to implement the rule of the majority and to protect the rights of the minority and the individual Delegate.

I am aware, as you are, that ideas arise from individuals, they are tested by discussion and reference to the facts and then they are implemented by the judgement of the majority.

> *In the interest of efficiency and equity we will request that resolutions be submitted early enough before the meeting of the House that they can be in the hands of the Delegates at the time of the meeting. We will recommend that no new resolutions be introduced after the second session so that adequate consideration can be afforded them by the reference committees.*

DURING THE FINAL session of the House the delegates selected by all of the county medical societies will elect the officers and councilors who will make a significant contribution of their time, and effort, in conducting the affairs of the Society. The offices to be filled by these elections are of great importance and it will be your Delegates' responsibility to select men you want and trust, and men who will properly represent you. Each election should and will receive the most careful consideration.

All members of MSMS are cordially invited to observe the deliberations of the House and to take part in the meetings of the reference committees. ☐

MSMS Annual Session Helps Assure Competency

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

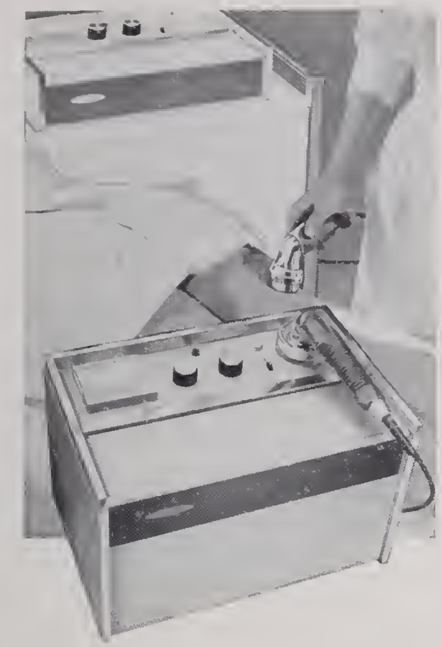
Graduate – "One who has received a degree or diploma on completing a course of study" (The American College Dictionary).

It is unfortunate that the dictionary utilizes the word completing. Graduation from medical school should be looked upon as the start of one's course of study rather than the completion.

Most graduates of medical school today will embark upon as many years of formalized training as they spent in medical school . . . and they will still not be a graduate by the above definition.

It is impossible (if one is to be a competent physician) to ever complete the course of study

(Continued on page 1036)



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in medical education—as it is a continual ongoing process.

The changes in technology, methodology, and pharmacology make the Buck Rogers' stories of our youth pale by comparison. Medical societies, hospitals, professional groups and medical schools have embarked upon massive programs in continuing medical education to keep physicians well informed and up-dated.

The MSMS Annual Scientific Session at the Sheraton-Cadillac Hotel in Detroit, September 25-26, is but one effort by your Society in continuing medical education. Four post-graduate day-long courses will be held by eminent authorities embracing "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases" and "Difficult Decision in Digestive Diseases." These are in addition to scientific exhibits, general sessions and specialty group discussions.

It is hoped that the members of MSMS will find the scientific session of the annual meeting rewarding and informative.

Medicare No Panacea

BY BROOKER L. MASTERS, M.D.
MSMS COUNCILOR

How has the public reacted to Medicare and proposals to expand it for those under 65?

There have been several surveys conducted by reputable organizations in recent months.

Many of our patients are referring now to a survey conducted by *Better Homes and Gardens* magazine. The study was conducted in cooperation with Opinion Research Corporation of Princeton. A total of 278,477 completed questionnaires, printed in the October and November, 1967, issues.

Better Homes and Gardens reports now that:

"Medicare evidently is not a panacea in the minds of the respondents. A strong 8 in 10 indicate an unwillingness to finance Medicare for those under 65 through additional Social Security taxes. In fact, 18 percent feel that Medicare should be done away with entirely (13 percent of the respondents feel that Medicare should be available to all.)"

There were other questions about medicine in the questionnaire. Let me quote the magazine again.

"Two-thirds of the respondents feel doctors' fees are high but justified by greater training and skill, in line with other professionals, and are quite fair."

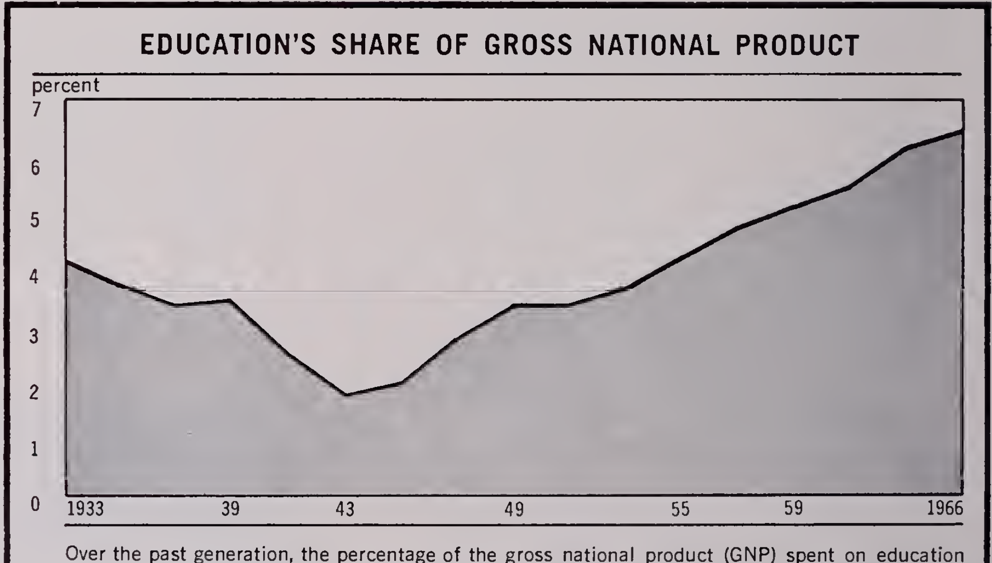
For years many physicians have argued that Medicare was unwise and costly. Despite these views, the physicians have cooperated to make Medicare work as effectively as possible.

The *Better Homes and Gardens* magazine reveals to all of us that quite a few citizens, too, see the law as unwise and costly in many regards. ☐

Thought Starter

The pattern of providing all or most of the training and education of medical students at a medical college would be like educating a forestry major at only a lumber yard.

—John G. Freymann, M.D.
Boston



Over the past generation, the percentage of the gross national product (GNP) spent on education has varied considerably—from a low of 1.8 to a high of 6.6 percent—but the trend has been steadily upward since 1943. The 1965-66 school year (the latest comparable period) ranked high both in terms of total school expenditures and share in the GNP.

Speaking of Malpractice Insurance....

Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

* Very Broad Coverage

* Competitive Premiums as Shown Below

Limits	Class 1	Class 2	Class 3	Class 4	Class 5	Premises Minimum Premium
100/300,000	$97.00	$170.00	$292.00	$389.00	$486.00	$33.00

(Premises Coverage Required with Professional Liability)

Class 1 —	PHYSICIANS — No surgery.
Class 2 —	PHYSICIANS — Minor surgery or assisting in major surgery on own patients.
Class 3 —	SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.
Class 4 —	SURGEONS — Specialists.
Class 5 —	SURGEONS — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Write for complete information as to coverage and premiums.

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Full speed ahead, Fred. These solid Cough Calmers can control that cough for 6 to 8 hours.
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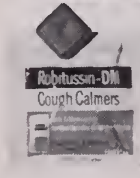
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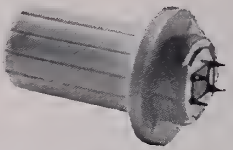

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(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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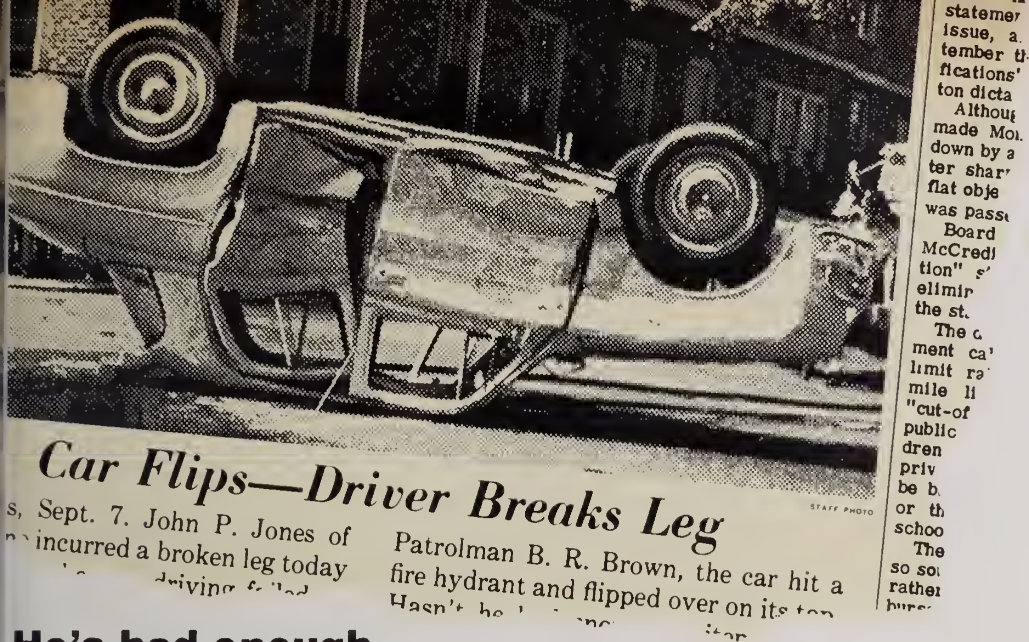

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Car Flips—Driver Breaks Leg

STAFF PHOTO

s, Sept. 7. John P. Jones of
incurred a broken leg today

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

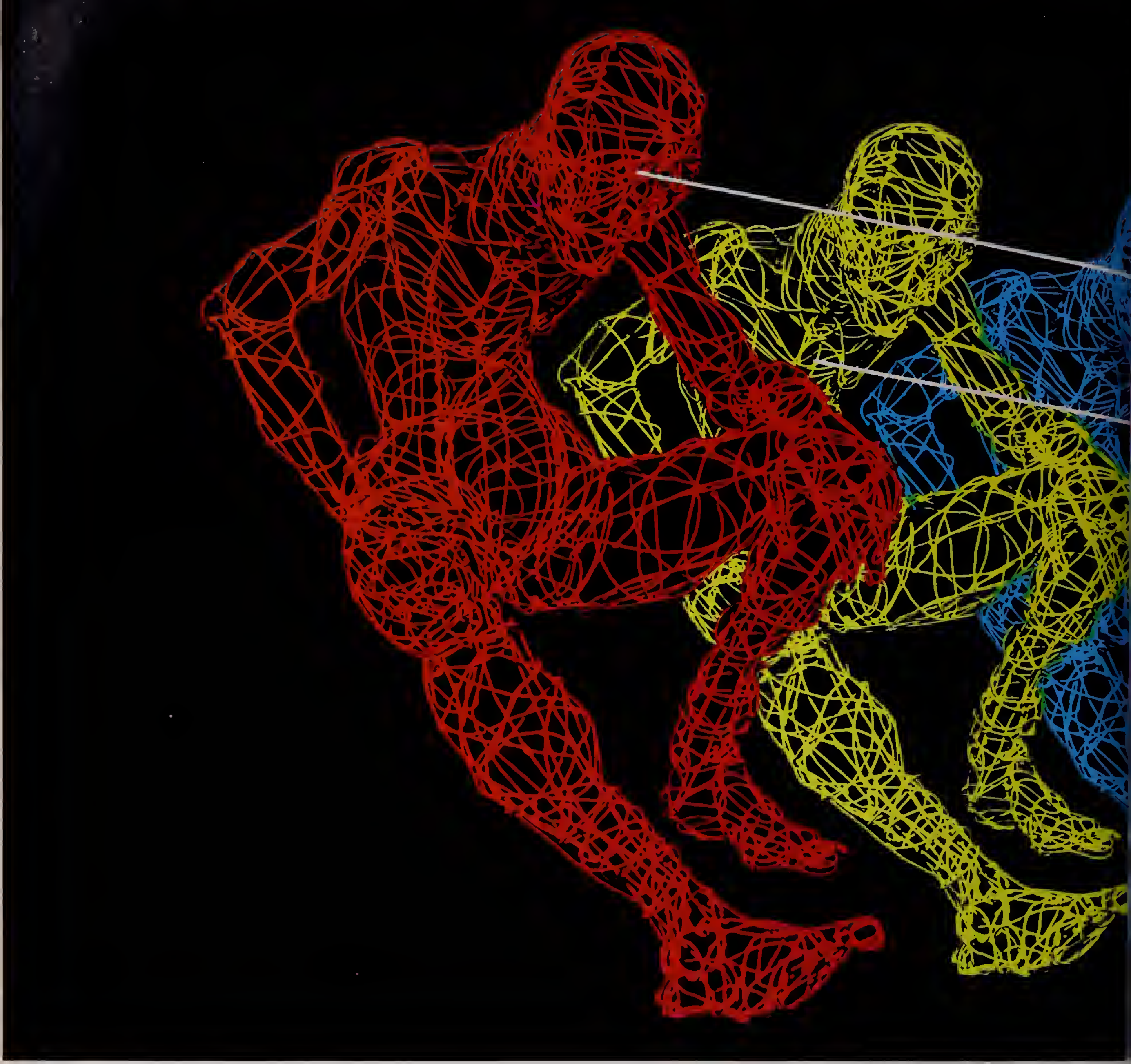
Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A-H-ROBINS

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropr
investigation to determine its cause or causes.
In pernicious anemia, the use of folic acid without adequ
vitamin B_{12} therapy may result in hematologic remission but n
rological progression. Adequate doses of vitamin B_{12} (parente
or oral with potent intrinsic factor as in Trinsicon® [hemat
concentrate with intrinsic factor, Lilly]) usually prevent, halt,
improve the neurological changes.
As with all preparations containing intrinsic factor, resista
may develop in some cases of pernicious anemia to the poter
tion of absorption of physiological doses of vitamin B_{12}. If res
ance occurs, parenteral therapy, or oral therapy with so-ca
massive doses of vitamin B_{12}, may be necessary. No single r
men fits all cases, and the status of the patient observed
follow-up is the final criterion for adequacy of therapy. Peric

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

linical and laboratory studies are considered essential and are ecommended.

dverse Reactions: In rare instances, iron in therapeutic doses roduces gastro-intestinal reactions, such as diarrhea or constiation. Reducing the dose and administering it with meals will inimize these effects.

In extremely rare instances, skin rash suggesting allergy has ollowed oral administration of liver-stomach material. Instances f apparent allergic sensitization have also been reported after ral administration of folic acid.

osage: One Pulvule twice a day. (Two Pulvules daily produce a tandard response in the average uncomplicated case of perniious anemia.)

ow Supplied: Pulvules Trinsicon® (hematinic concentrate with ntrinsic factor, Lilly), in bottles of 60 and 500. [032568]

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"will this one taste O.K.?"

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American Map Co., Inc., New York, No NY 388

See inside fold for product summary.

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Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline–or analogue–can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system —anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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BOOK REVIEWS

HEREDITY, DISEASE AND MAN: GENETICS IN MEDICINE. By Alan E. H. Emery. $6.95 247 pp., illustrated. University of California Press, Berkeley and Los Angeles, 1968.

This book presents a very excellent review of our present knowledge of genetics as it relates to man. The author, Doctor Emery, is Chairman of the Department of Human Genetics at the University of Edinburgh. The text is very well written with clear explanations and good illustrations of the more complicated aspects of cytogenetics. Since this was not intended to be a textbook for students in medicine, some parts of the material are somewhat superficial. An example of this is the description of DNA and the chemistry of genes in which many of the details are omitted. To compensate for this are the frequent references to historical development of various aspects of genetics that often are not included in the more rigid frame of a textbook.

The material covered is quite comprehensive beginning with the chemical basis of inheritance and the description of DNA and RNA. The chromosomes and chromosomal abnormalities are discussed and illustrated. It is unfortunate that photographs were not used instead of line drawings to illustrate some of the abnormalities that are described throughout the text. The line drawings simply do not adequately portray the characteristic findings for the reader who is unfamiliar with them. Methods of inheritance such as dominant, recessive and sex-linked aspects are very adequately described. An unusual and very excellent chapter is that on pharmacogenetics. The material presented here is often omitted from other books on the subject. It seems to this reviewer that this chapter conveys as well or better than most others the intricacies of the influence of genetics on our lives other than the purely structural ones. Population and natural selections are discussed as well as the effects of radiation of human hereditary. A ten page glossary adds considerable value to the book and makes it easier for the reader to look up unfamiliar words rather than referring back to the chapter in which these words first appeared.

Any physician who is interested in genetics would benefit by reading this text. If he has kept up with developments by reading the review articles as they appear in our medical journals, he probably will find the presentation by Doctor Emery to be too superficial to be of great value to him. If, on the other hand, the physician wants a good review that is not too complicated, this book would adequately fill that need. The text is purely descriptive and no techniques or details of methods are given. Most chapters are followed by a very adequate though brief list of references. With the exception of lack of photographs, the illustrations are excellent and supplement the text very well.

George H. Lowrey, M.D.

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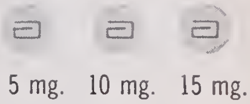

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Review of "Prevention of Highway Injury," edited by Melvin L. Selzer, M.D., Paul W. Gikas, M.D., and Donald F. Huelke, Ph.D. and published by the University of Michigan, Ann Arbor, Michigan.

This is a book of thirty chapters individually written by authors from the United States, Canada and Europe, and divided into four general headings of The Alcoholic Driver, Vision and Medical Impairment, Biomechanics, and The Second Collision. The material in the first two general headings is of greater practical value to the physician interested in traffic safety. I would recommend especially the two articles written by Julian A. Waller, M.D., of the California Department of Public Health: Drinking Drivers and Driving Drinkers — The Need for Multiple Approaches to Accidents Involving Alcohol; and The Contribution of Medical Impairment to Traffic Accidents.

In the first chapter, Doctor Waller emphasizes the now accepted fact that the majority of drinking accidents and violations involve persons with alcoholism, and that the current practice of emphasizing moral responsibility with slogans such as, "If you drive, don't drink," and with heavy fines and suspension of licenses for drunken driving will have little or no beneficial effect. For many persons with alcoholism the driver's license will have to be revoked until the alcoholism improves under treatment. He suggests that many social drinkers do drink and drive despite admonition, and that we can teach them how to limit their risk by eating with their drinks, by not drinking more rapidly than they can metabolize their alcohol (about one hour for each drink), and by waiting at least a half hour after their last drink before driving.

In the chapter on Medical Impairment, Doctor Waller makes several interesting observations based on available studies from a number of sources. Acute medical conditions are not felt to be an important cause of accidents. However, more subtle physiologic changes related to aging and chronic conditions appear to be a contributory factor in a substantial proportion of accidents. Medical impairment from chronic conditions other than alcoholism in a factor in 15-25 percent of all accidents. However, licenses should be revoked only for persons with the most severe illness, representing, at most, a third of the medical groups and five percent of all drivers. This is the group with accident risk in excess of 3-4 times that of the general population.

This book has two minor deficiencies. The type is considerably smaller than that used in current medical texts and magazines. An additional 75 pages would have produced a more easily read book. Also, only two chapter authors out of thirty had summaries at the beginning of their chapters.

John R. Rodger, M.D.
Bellaire, Michigan

State Researchers Work On Adenine Project

Research scientists at the Michigan Department of Public Health are taking part in an investigation to determine if a new additive, may be suitable for prolonging the useful life of donated blood. The Michigan study is primarily concerned with the effect of adenine on the various blood products that are made from whole blood.

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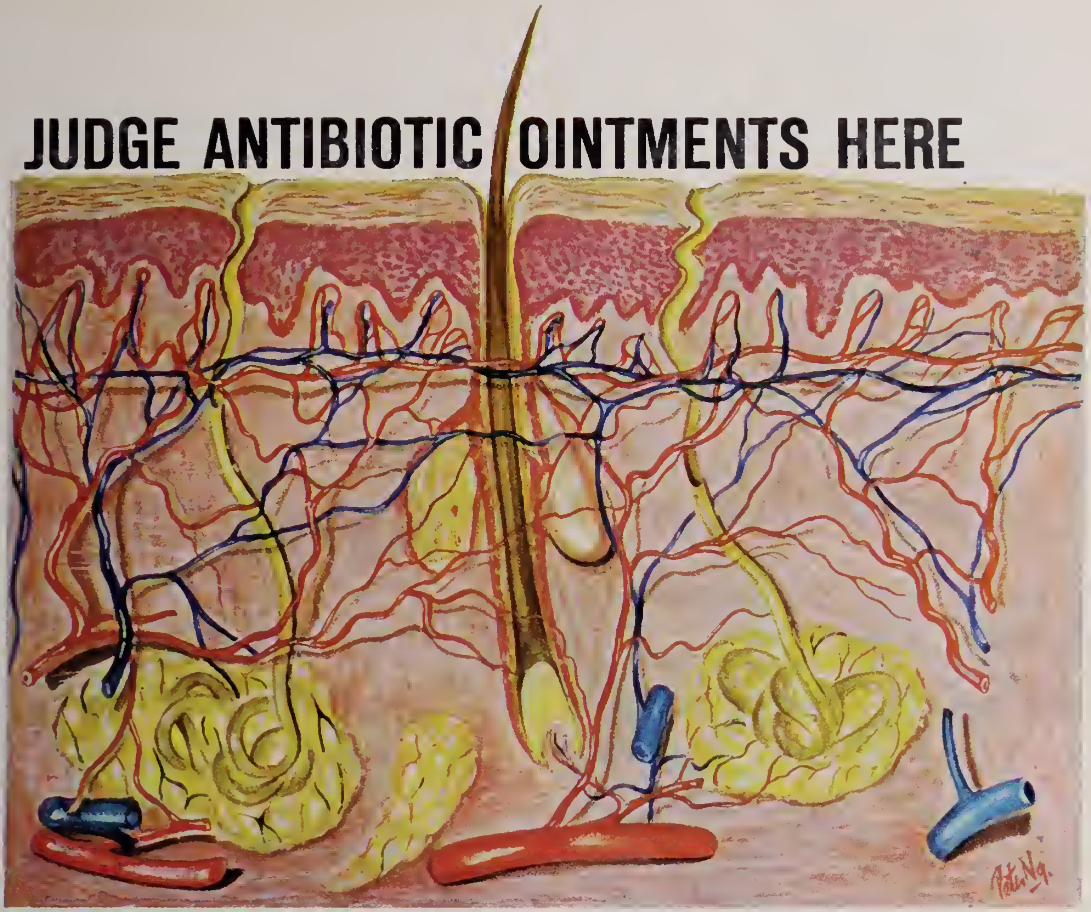

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Power Mower Injuries Of the Hand

J. JOSEPH DANYO, M.D.
YORK, PA.
KIM K. LIE, M.D.
ROBERT D. LARSEN, M.D.
JOSEPH L. POSCH, M.D.
DETROIT

INTRODUCTION

During the past 25 years the power lawn mower industry has achieved a substantial volume of sales. The industry came of age with the advent of the rotary unit, which was developed as a means of coping with the steel shortage during World War II. Mowers prior to that time were of the reel type.

The power mower market in the United States is reliably reported as consisting of 25 million units. Upwards of five million new mowers are sold yearly, and of these, one million units are purchased by new owners.[1]

These convenient labor-saving machines are a boon to the welfare of our landscape and leisure time, but if handled incorrectly, they can become a menace to our families and neighbors. The industry has waged an excellent campaign of power mower safety for the past 12 years. And manufacturers are designing their machines to lessen the possibility of accidents occurring from missiles and direct contact with moving parts. Yet, the number of accidents continue to rise in astronomical proportions. Most mishaps nowadays, are due to the operator's carelessness.

There is no accurate estimate of the number of power mower injuries occurring in the United States. McClure[2] reported a series of 794 injuries in a survey in Georgia in 1955 and 1956. Of these injuries, 553 were caused by direct contact, and 143 cases involved injuries to the hand or fingers. Permanent disability occurred in 14 per cent of the cases. Two types of injuries were noted: one type due to direct contact, which occurred in 70 per cent of the cases; and another type due to missiles thrown by the power mower in 30 per cent of the cases. McClure[3] mentioned three reasons for the occurrance of accidents.

1. Faulty design of the mower.
2. Carelessness of the operator.
3. Injuries by missiles which are thrown by the power mower or fragments of mower blades.

Bergman[1] reported on a series of 110 power mower injuries during a five-month period. The severity of the injuries was apparent because 30 per cent of cases required hospitalization.

CASES

Our study deals with 110 power mower injuries of the hand encountered in private practice from 1954 to 1967 inclusive. The age of the patients ranged from 2 to 83 years. The average age of the patient was 32 years. The majority (85 per cent) of the patients were male. Children under 14 years of age were involved in 23 cases. Permanent disability in children occurred in 30 per cent of the cases. Of note was the fact that virtually all of the injuries to children occurred while the power mower was unattended and the motor was running.

Eighty-five per cent of the cases were severe injuries requiring hospitalization for surgical repair. The right hand was involved in 55 per cent of the cases and the left hand in 45 per cent. Single digit injuries occurred in one-third of the cases. The remaining two-thirds of the cases involved two to four digit injuries, and in four cases all digits on the hand were injured. In addition to soft tissue injury, 80 per cent of the cases had an injury to the bony structure. Thirty per cent of the injuries resulted in amputation of the digit. Permanent disability occurred in 23 per cent of the adults. The average loss of time from work in the adults was six weeks.

ETIOLOGY

In our series, our patients readily admitted to being at fault. The rotary mower was involved in 91 per cent of the cases, and the reel type mower in 9 per cent of the cases. By definition, the rotary mower is one that has a horizontal blade (s) that rotates about a vertical axis, cutting by velocity alone, without a stationary bed-knife. Rotary cutter blade speed is 21,000 feet-per-minute.[5] These

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Doctor Danyo, a fellow in hand surgery and formerly at Grace Hospital, Detroit, is now in York, Pa. Doctors Lie, Larsen and Posch are all with the Department of Surgery at Grace.

figures compared exactly to the ratio of the same mowers in use today.

No particular brand of rotary mower stood out above the others in accounting for the accidents. In 82 per cent of the cases the motor was running at the time of the injury. Wet grass with resulting clumping accounted for 25 per cent of the cases. In these instances, the wet grass clumps led the operator to reach into the opening in the blade housing without knowing the close proximity of the blade to the grass discharge chute. The guard was absent over the blade in 51 per cent of the cases. However, the guard was cited as being solely responsible for the injury in 33 per cent of the cases.

TREATMENT

The majority of our cases required hospitalization for surgical debridement and repair. Surgical debridement of the badly crushed digits was performed, and where primary closure was not possible, free skin grafts or cross finger pedicle grafts were performed. Thirty per cent of our cases required amputation of the injured digit. Open reduction and immobilization of fractures was required in 60 per cent of the cases. Associated tendon injuries were not repaired primarily.

CONCLUSIONS AND SUMMARY

Power mower injuries will continue to be more prevalent commensurate with the increased use of these appliances. Direct contact injuries are caused by carelessness of the operator. The majority of the cases required hospitalization for surgical repair. The average length of temporary disability was six weeks, and permanent disability resulted in 23 per cent of the adults. Multiple digit injuries were noted in 70 per cent of the cases. It is apparent that power mower injuries caused by direct contact are severe disabling injuries resulting in economic hardship. Better public awareness on the inherent dangers of power lawn mowers is imperative to prevent these injuries. A nation-wide safety educational program directed to the manufacturers, sellers and users of power mower equipment is necessary.

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Evaluation of a Screening-Technique For Urinary Tract Infections In Diabetic Out-Patients

ABSTRACT

Significant urinary tract infections have been demonstrated in 14.6 percent of a randomly selected group of 212 diabetic out-patients. A commercial screening test (Testuria) has also been evaluated as a means of identifying such patients. Properly safeguarded, the screening test has been found to be useful in the management of an out-patient population. No false negatives were recorded; a negative Testuria result was always associated with a negative quantitative agar plate culture. But the incidence of false positives was high. Some 30 percent of all positive Testuria results were associated with insignificant colony counts on hospital agar plates in single comparison studies.

"Suspicious" or positive results with Testuria should be confirmed by standard agar plating of another urine specimen before diagnostic or therapeutic decisions are taken. Negative results with Testuria may be accepted at face value.

BY ALI ABBASI, M.D.
LAWRENCE POWER, M.D.
DETROIT

INTRODUCTION

Urinary tract infections are common in patients with diabetes mellitus. They have been reported to be 3-4 times more common in diabetic populations by autopsy studies,[1, 2] renal biopsy,[3] and clinical studies.[4] Recent emphasis on the value of quantitative urinary bacterial cultures in identifying significant urinary tract infection had led to the development of a number of procedures for this purpose.[5] In the present study we have compared the results obtained with a commercially-available urine culture technique (Testuria) with a standard hospital agar plate procedure, in a diabetic out-patient population.

MATERIALS AND METHODS

During the study, 212 randomly-selected out-patients with diabetes mellitus were screened for urinary tract infections. The study was done over an 8-month period during two clinic mornings each week. The composition of the population is shown in Table 1 and the modes of management of their diabetes in Table 2. A mid-stream clean catch specimen was obtained by the patient after instruction from the nurse. The external genitalia of both male and female patients had been washed with a solution of green soap and 1:1000 zephiran. Routine chemistries and a microscopic examination were also performed on each urine specimen.

TABLE 1

Types of Patients Screened

	Number	Negro	White	Mean Age
Female	144	123	21	55
Male	68	46	22	57
Total	212	169	43	56

TABLE 2

Diabetes Management of the Screened Patients

Treatment	Number	Percent
Insulin	96	45
Chlorpropamide	52	24.5
Tolbutamide	26	12.2
Phenformin	3	1.4
Phenformin and Sulfonylurea	12	5.6
Diet Alone	16	7.5
New Patients	9	4.2

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In the technique followed, an inoculum of the specimen was delivered to Testuria plates by means of the filter paper strip which comes with the plates, was dipped into the urine, and applied to the culture medium. The plate was then incubated in the supplied incubator at 37° C. for 24 hours, and the number of colonies counted.

After Testuria plating, the remaining urine was sent to the bacteriology laboratory of Detroit General Hospital and plated by means of a standard loop designed to handle 0.01 ml. Gram positive organisms were sought on an eosin methylene blue medium, and colony count estimates made the following day. Atypical organisms and non-lactose fermenters were further identified through standard bacterial-biochemical flow techniques.

RESULTS

A total of 212 patients were studied and 288 paired Testuria and agar plate cultures performed. Testuria colonies were counted and classified into three groups: Group I contained 0-2 colonies; Group II, 3-25 colonies; Group III, more than 25 colonies. As suggested by the manufacturer, Group I was considered equivalent to a quantitative plate count of less than 25,000 bacteria per ml. of urine, and interpreted as negative. Group II was considered to be "suspicious," and the manufacturer recommends that cultures in this group be repeated. Group III was said to be equivalent to a quantitative plate count of 100,000 bacteria or more per ml. of urine. The results of our comparisons are shown in Table 3. More than 50,000 bacteria colonies per ml. of urine are considered, at this hospital, to signify a urinary tract infection.

Group I or negative culture results (Table 3) were in agreement with the quantitative plate count. The great majority of Group II, or "suspicious" results did not signify urinary tract infection when compared to the agar plate standard. This tendency to over-diagnosis extended into the Group III comparisons where 16 out of 53 Testuria positives did not prove to be significantly infected by standard hospital agar plate comparisons.

Thirty-one of 212 screened patients had significant bacteriuria, for a prevalence of 14.6 percent. When sexes were considered separately, 5 of the patients were male, and 26 were female, for a 7.3 percent and 18 percent prevalence, respectively. Twenty-four patients were asymptomatic, while 9 (22.5 percent) had mild-to-moderate symptoms, such as dysuria and back or flank discomfort. No patient was febrile. The incidence of comparable symptoms in those patients screened who did not have significant bacteriuria, was 17.6 percent (32 of 181), and indicates the need for a routine screen for infection regardless of the patient's symptoms, or lack of them. Proteinuria was demonstrated in 66.6 percent of the specimens from patients with bacteriuria, while it was present in only 36.9 percent of the specimens of patients without significant bacteriuria.

Examination of centrifuged urinary sediments (Table 5) revealed a significant deposit of bacteria (++ or more) in 63.6 percent of infected urine specimens, but in only 11.5 percent of uninfected specimens. Other findings on microscopic examination, such as white blood cells, mucus, and casts were not significantly different between infected and non-infected groups (Table 5).

TABLE 3

A Comparison of Testuria and Standard Quantitative Agar Plate Cultures

(Clean-catch Urine Specimens of Diabetic Out-patients)

Testuria Results	Agar Plate Results	Number of Comparisons
0-2 colonies	< 10,000	191
3-25 colonies	< 10,000	39
	10,000-50,000 ..	4
	> 100,000	1
> 25 colonies	< 20,000	16
	> 50,000	37

TABLE 4

Organisms Responsible for Urinary Tract Infections
(More than 50,000 Organisms per ml. on Agar Plate)

	E. coli	Aerobacter	Proteus	Gamma Streptococcus
Male	2	3	0	0
Female	17 (9 pts)	10 (9 pts)	4 (3 pts)	1
Total	19	13	4	1
Percentage	51.3%	34.1%	10.8%	2.7%

TABLE 5

Microscopic Findings in Urine Specimens
Of Screened Diabetic Patients

Findings per high power field	Incidence	Percentage
++ or more bacteria	21 of 33 infected specimens 17 of 147 uninfected specimens	63.6% 11 5%
more than 10 WBC	9 of 33 infected specimens 25 of 147 uninfected specimens	27.2% 17%
more than 20 WBC	7 of 33 infected specimens 14 of 147 uninfected specimens	21.2% 9.5%
Casts	10 of 33 infected specimens 55 of 147 uninfected specimens	30.5% 36.0%

DISCUSSION

The prevalence of urinary tract infections in our male and female diabetic out-patients, as revealed by this study, is 14.6 percent. When the sexes are considered separately, 7.3 percent of the screened males and 18 percent of the screened females have significant bacteriuria. Observations in this range have been reported by other workers[6, 7] and underline the need for a routine screening procedure among diabetics, whether they are symptomatic or not, if infection is to be recognized and functioning tissue saved. Testuria provides help in this objective, but tends to err on the side of false positives. Positive or "suspicious" results with Testuria are an indication for repeat evaluation of the patient and standard agar plating of another urine specimen. Our experience indicates that negative results with Testuria are quite reliable.

Sixteen specimens in Testuria Group III yielded quantitative agar plate counts of less than 20,000 bacteria per ml., but in 5 of these specimens there were several grossly different bacterial colonies. This in itself suggests contamination. If these 5 specimens are disregarded, the false positives occurring with Testuria culture become 11 of 288 urine specimens, or 3.8 percent. The likelihood that a positive Testuria result signifies urinary tract infection is increased if the urine specimen also contains protein and shows deposits of bacteria in the centrifuged sediment.

ACKNOWLEDGEMENT

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The Treatment of Trigeminal Neuralgia And Other Facial Pain with Carbamazepine

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DETROIT

In recent years, there have been many reports in the literature on the successful treatment of trigeminal neuralgia with Carbamazepine (5H-dibenz- [b, f]-azepine-5-carboxamide),[1-7] an anticonvulsant drug developed by Geigy Pharmaceuticals. The brand name is Tegretol.®

This paper will report our experience in treating 192 patients. Table I summarizes our initial group of 123. Ninety-eight patients had true paroxysmal pain in the distribution of the trigeminal or glossopharyngeal nerve. Sixteen patients had facial pain which did not meet the characteristic features of trigeminal neuralgia, either by type, location or duration of symptoms. The remaining nine patients were treated with Tegretol in the hope that it would help in the management of these difficult problems.

In the initial 18 months of our use of Tegretol, the active compound was compared with a placebo in a double blind study. Tegretol or the placebo was given to the patients in previously coded packages. The patients were re-evaluated after a few weeks, the code was checked and if they were on the placebo and without relief, they were given the active compound. As soon as we were convinced the Tegretol was effective (Table II), we discontinued the double blind study. The placebo was effective in only 10 percent, compared to 71.3 percent when Tegretol was given.

Tegretol is an iminostilbene derivative related to the tranquilizer, Tofranil.® It is not related to diphenylhydantoin.[8] The usual starting dose was 100 milligrams, three times per day. The patient obtained relief on this dosage usually within 12

TABLE I

CONDITIONS TREATED

Trigeminal neuralgia	90
Trigeminal neuralgia and M.S.	4
Atypical facial pain	15
Atypical facial pain and M.S.	1
Glossopharyngeal neuralgia	4
Post-herpetic pain	4
Tabetic pain	1
"Thalamic" pain	2
Hemifacial spasm	1
Pain related to neoplasm	1
TOTAL	123

TABLE II

RESULTS OF DOUBLE BLIND STUDY

	TEGRETOL		PLACEBO		TEGRETOL AFTER PLACEBO	
	RELIEF	NO RELIEF	RELIEF	NO RELIEF	RELIEF	NO RELIEF
Trigeminal neuralgia	30	7	2	14	12	1
Atypical facial pain	1	5	0	3	1	0
TOTAL	31 (71.3%)	12 (28.7%)	2 (10%)	17 (90%)	13 (92.8%)	1 (7.2%)

TABLE III

RESULTS OF TEGRETOL

	SATISFACTORY		UNSATISFACTORY	
Trigeminal neuralgia	79	(88%)	11	(12%)
Atypical facial pain	3	(20%)	12	(80%)
Other conditions	2*	(14.6%)	11	(85.4%)

* Glossopharyngeal neuralgia

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hours. If this was insufficient, the dosage was increased after a few days to 200 milligrams, three times a day. After relief was obtained, the dosage was decreased to the lowest dosage which offered satisfactory relief and frequent attempts were made to discontinue the medication.

In the initial two years of the study, treatment was limited to three months by Federal Drug Administration Regulation. Later, this period was extended and finally removed.

RESULTS OF TREATMENT

A satisfactory response consisted of enough pain relief so that the patient desired to remain on the medication. There was complete pain relief in almost all of the cases. The medication was given to 118 of the 123 patients; the other five received the placebo alone. Trigeminal neuralgia had a favorable response in 88 percent of the cases. Only 20 percent of the patients with atypical facial pain had a satisfactory response (Table III). Of the remaining 13 patients, only two obtained satisfactory relief and both of these had glossopharyngeal neuralgia. Ninety patients had trigeminal neuralgia. Complete pain relief was obtained in 46.6 percent of these patients when they were on the medication (Table IV). The pain returned immediately when the medication was stopped. Of the remaining patients who had complete relief, 14.4 percent had only initial relief with the pain returning while they were on the medication and 14.4 percent had no return of the symptoms when the medication was stopped. This last group of patients probably was in a period of remission that is usually seen in trigeminal neuralgia.

In our final tabulation, we include 69 additional patients, bringing the total number to 192 patients treated with Tegretol. Of this total, 48 patients with trigeminal neuralgia underwent surgical procedures for further relief of symptoms. Table V lists the reason for the surgical treatment. In addition, three patients refused to take the medication when offered.

SIDE EFFECTS

Tegretol is a potent drug with frequent side effects, mainly dizziness, ataxia, nausea and vomiting (Table VI). Most of the side effects are transient and either disappear after a few days or by a reduction in the dosage. A large number, however, were considered severe enough to necessitate stopping the medication. These side effects usually cleared rapidly when this was done.

A white blood count, hemoglobin, reticulocyte count and blood smear were obtained every two weeks, and a serum creatinine, transaminase, urine analysis and alkaline phosphatase every four weeks.

One death occurred due to aplastic anemia and toxic hepatitis. This patient refused to get the re-

TABLE IV

TYPE OF RESPONSE TO TEGRETOL IN TRIGEMINAL NEURALGIA

RESULTS	No.	%
No relief	9	10
Moderate relief	8	8.8
Complete relief		
While on medication	42	46.6
Transient	13	14.4
Permanent	13	14.4
Permanent on medication and surgery	5	5.8
TOTAL	90	100.0

TABLE V

REASONS FOR SURGERY IN PATIENTS WITH TRIGEMINAL NEURALGIA AFTER TEGRETOL TRIAL

Good relief but desired more permanent cure	10
Good relief but severe side effects	7
Inadequate relief	
No relief	12
Moderate relief	9
Transient relief	10

TABLE VI

SIDE EFFECTS DUE TO TEGRETOL

SIDE EFFECT	TRANSIENT	SEVERE
Dizzy or ataxic	18	11
Nausea and/or vomiting	6	2
Drowsy	3	3
Rash	1	2
Multiple sclerosis worse	1	2
Abnormal liver function test	0	2
Numbness	1	0
Aplastic anemia and toxic hepatitis	0	1*

* Death

quired laboratory tests in the last two months of treatment, although he was warned repeatedly about the potential hazards of the medication. The aplastic anemia was discovered when the patient underwent emergency surgery for an incarcerated hernia. He had not been taking any other medication at the time and no other cause was found.

A second patient had an elevation in the transaminase, alkaline phosphatase and bilirubin. The jaundice was due to intrahepatic bile stasis and slowly improved when the medication was stopped. A liver biopsy revealed a normal liver architecture with much bile pigment compatible with intrahepatic cholestasis. No other cause for the jaundice was found when the patient was worked up.

DISCUSSION

The mechanism of the pain production in trigeminal neuralgia is still undetermined. There are two primary theories about the etiology of trigeminal neuralgia: One is peripheral; and the other central.

Dandy[9] in 1934 thought that the cause of trigeminal neuralgia was located peripherally in the sensory root of the trigeminal nerve. The fifth, seventh, ninth and tenth cranial nerves are all subject to tic pain. All of these roots have parasympathetic fibers, including the fifth nerve.[10] The parasympathetic fibers of the trigeminal nerve are thought to innervate the erectile tissue of the vibrissae which are present in lower mammals.

Gardner[11] postulated that trigeminal neuralgia is the result of a retained phylogenetic reflex. The afferent tactile stimulus causes an afferent (parasympathetic) response which excites the pain fibers through an artificial synapse produced by pressure on the nerve root. The pressure causes a localized demyelination and short circuits two adjacent axons. Electron microscopic examination of the ganglion cells of the trigeminal nerve showed vacuolation and segmental demyelination with denuding of the axis cylinders.[12] The various causes of pressure on the root have been arterial compression,[13] petrous ridge compression,[14] aneurysm, tumors and the internal carotid artery.[15]

The central etiology of tic douloureux has been extensively investigated and supported by King.[16] Stimulation of the infraorbital nerve in a cat gives an afferent spike followed within 5 m. sec. by a complex of deflections from the brain stem to the periphery. This is thought to be a dorsal root reflex.[17] This reflex is probably polysynaptic as is the linguo-mandibular reflex which is depressed by Tegretol. This reflex can be increased by strychnine injections in the region of the nucleus caudalis of the fifth nerve[16] with a marked over-reaction to a light tactile stimulus in the distribution of the trigeminal nerve. King thinks that a wide number of lesions within the central nervous system affect the excitability of this system which has its synapse in the nucleus caudalis. Lidocaine, Hydantoin and possibly Tegretol depress this reflex.

Strychnine renders the nervous system more excitable by lowering the threshold of excitability, by preventing the loss of excitability from continuous stimulation and by prolonging the period of hyperexcitability which normally follows nerve stimulation.[18] Tegretol has a prominent anticonvulsant effect with respect to strychnine and counteracts these effects. Tegretol possibly does the same in trigeminal neuralgia by raising the threshold of excitability and by interrupting the period of hyperexcitability caused by either (1) short circuiting of two adjacent damaged neurons, as in the peripheral theory of trigeminal neuralgia or (2) by an increased dorsal root reflex from a central cause.

Our results are in agreement with the studies in the literature.[1-7] We have found Tegretol to be very effective in the treatment of trigeminal neuralgia and also some use in glossopharyngeal neuralgia. It is generally ineffective in treating atypical facial pain and is about the same as the placebo. Unfortunately, the incidence of side reactions are high and potentially dangerous. There have been three other reported cases of aplastic anemia.[5, 19] This is by far the most serious of the side effects and frequent laboratory tests must be made as suggested by the manufacturer. In our experience, a large number of the patients eventually ask to have a surgical procedure done, which has proved to be less costly, more permanent, and is free of serious complications.

In our opinion, Tegretol will have its greatest use in:

1. Patients with an acute attack of trigeminal neuralgia while they are awaiting surgery.
2. Patients who are poor surgical risks because of age or health.
3. Patients in whom the diagnosis is not clear and further time for evaluation is necessary.
4. Patients who would prefer to postpone a surgical procedure.

It should not be used in treating atypical facial pain or other pain problems because of its toxicity and lack of effectiveness in these conditions.

SUMMARY

One hundred ninety-two cases of trigeminal neuralgia, atypical facial pain, and various other conditions were treated with Tegretol. Three to six hundred milligrams of Tegretol were sufficient to stop 88 percent of trigeminal neuralgia within one day. It was ineffective in treating atypical facial pain and was moderately effective in glossopharyngeal neuralgia. The medication has frequent and potentially serious side effects and one of our patients died from aplastic anemia. Although the medication is effective, many of the patients eventually decided on surgical procedure for more permanent control because of the reasons listed in Table V.

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Acute Myocardial Infarction Preceding Diabetes Mellitus

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DETROIT

That diabetes mellitus occurring in persons under fifty years of age (and probably at any age) is an accelerating factor in atherosclerosis has been well known for many years.[1,2,3] This is well illustrated by the higher frequency of coronary artery disease and peripheral vascular disease in the diabetic population as compared to the general population.[2,4]

Over the past several years we have become increasingly aware that some patients suffering from myocardial infarction may have hyperglycemia. This abnormality reverts to normal within a few days in the majority of cases, but often a few patients will continue as true diabetics. In one series, Wahlberg of Sweden subjected 190 survivors to intravenous glucose tolerance tests after recovery from their initial attack of myocardial infarction, and found frank diabetes in 12% of those under 50 years. The prevalence increased with age.[5]

This is one side of the coin. The following case history illustrates the obverse—namely, that myocardial infarction may portend diabetes.

J.P., A THEN 47-YEAR OLD MALE EXECUTIVE, was seen initially because of the sudden onset of nausea and vomiting occurring sporadically during the preceding night, but unaccompanied by chest or abdominal pain. Blood pressure, pulse, respiration were normal. Temperature was 100°F. Except for a murmur consistent with mitral stenosis, no other abnormalities were noted.

The patient had scarlet fever at ten years of age. His family was informed that he had developed a "heart murmur." Despite this the patient maintained an active life without restrictions.

There was no known family history of diabetes, but his father, a paternal uncle, and an older brother all had died of coronary artery disease prior to 50 years of age. Though hypertensive, his mother was alive at 78 years as were four siblings. While hospital arrangements were in progress, the patient became sweaty and anxious. On re-examination the blood pressure was 60/40. Atrial fibrillation with a rapid ventricular rate was observed. The admitting electrocardiogram confirmed the arrhythmia and revealed an extensive acute anterior myocardial infarction.

On admission and during his hospital stay fasting and post-prandial blood sugars were normal. One year later on routine examination following a three-day, 300-gram carbohydrate diet, a four-hour oral glucose tolerance test was normal. Two years later a two-hour post-prandial blood sugar was 170 mg. per 100 ml. (true glucose). The patient was asymptomatic and had not regained his pre-infarct weight. A four-hour glucose tolerance curve at this time was positive for diabetes. With dietary manipulation, the patient has maintained excellent control of his blood sugar levels.

This case merely serves to highlight the fact that acute myocardial infarction may be a "prediabetic" sign. Following myocardial infarction, patients should be evaluated at appropriate intervals for diabetes.

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Faulty Neurologic Integration With Perceptual Disorders in Children

AN ABRIDGED TREATMENT APPROACH; A TWO-DIMENSIONAL PROGRAM OF METHYLPHENIDATE AND PSYCHOLOGIC MANAGEMENT

ABSTRACT: The high incidence of learning disorders among school children, based on perceptual abnormalities with concomitant emotional problems, poses a burdensome responsibility on the community and the medical profession. Various modalities, involving prolonged re-training in special clinics and institutions, have not only deferred beneficial gains for the afflicted children, but have permitted exploitation of their parents by para-, as well as pseudo-, medical groups. Such considerations have prompted our promulgation of a practical, expeditions approach to the therapy of perceptual disorders in children with faulty neurological integration, utilizing, for the most part, the services of a physician and clinical psychologist in a private practice setting. Our experiences with over 100 such cases are delineated; and, of these, 3 representative case histories are presented in detail. Methylphenidate, the drug of choice, together with psychologic support, effected highly successful results rapidly, and often dramatically.

BY SAMUEL J. NICHAMIN, M.D.
GEORGE D. BARAHAL, Ph.D.
BOTH OF DETROIT

During the past decade, educators, psychologists, and physicians have been inundated with a bewildering onslaught of investigations in the rapidly expanding field of learning disabilities associated with minimal cerebral dysfunction. Emotional problems engendered by a child's educational failures comprise an impressively large segment of the syndrome. Those concerned with emotional, psychologic, and environmental problems have been prone to ignore or neglect the use of drugs, whereas organicists have concentrated on psychopharmacologic products. Hence, no definitive therapy has been promulgated; and beneficial results, by and large, remain indeterminate for either modality. In such an area of indecision regarding effective therapeutic methods, parents, teachers, and patients can readily succumb to attitudes of frustration and despair.

The hyperkinetic syndrome, or its counterpart, the hypokinetic (lethargic) child with sluggish mentation, has a behavioral cluster which consists primarily of motor restlessness of varying degrees, impulsivity, and distractibility in perceptual and congnitive spheres. Comprehensive, basic data garnered for the study of this clinical entity, has hitherto necessitated the provision of a large, multidisciplinary staff organization, consisting of administrators, psychiatrists, pediatricians, opthalmologists, neurologists, psychologists, social workers, teachers, and speech or hearing specialists. For the practical application of available knowledge in this vital area of learning disorders, an extensive proliferation of these medical centers or child guidance clinics would be an unquestionable desideratum. However, in terms of community and financial resources, a requisite program for such elaborate complexes would represent an unattainable and realistic expectation.

To avoid semantic confusion in the nosology of brain dysfunction, with its implication of brain damage or mental retardation or both, we propose the term, "faulty neurologic integration with perceptual disorders" for children who are thus afflicted. In the psychologic and educational spheres, emphasis has centered on motor re-learning, with training exercises in coordination, remedial reading, and even cultist-type abstruse methods provided in special private schools and institutes, with results of questionable authenticity. Furthermore, these training procedures are prohibitively expensive and of prolonged duration.

Despite the gamut of disparate factors comprising this vital problem of perceptual and learning disorders in children, effective integration of all

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Generic and Trade Names of Drugs
Methylphenidate hydrochloride—Ritalin (Ciba)
Amphetamine sulfate—Dexedrine

relevant information from the various disciplines involved can be unreservedly entrusted to the family physician. In a simplified, basic, two-dimensional program of methylphenidate and psychologic management, the clinical psychologist performs an indispensable function. He is responsible for the assessment of all mental and emotional findings, and should be involved with every phase of treatment.

In the light of this joint endeavor, combining the medical and psychologic responsibilities in a private office type of practice, independent of an elaborate, and often redundant hierarchy of interdisciplinary functions, we are herewith presenting our experience with over 100 patients with this syndrome. Our primary remedial purpose was to limit our efforts to the use of a specific, psychostimulant drug (methylphenidate) of proven efficacious value in such children,[2,3,4] together with the provision of psychological support for the patient and family. The latter function does not imply exhaustive, long-term, intensive psychotherapy.

In view of the array of publications in this field, documented and qualified, it would appear redundant and beyond the scope of this paper for us to re-explore the areas of diagnosis and the neurophysiological theories for drug therapy of hyperkinesis with perceptual disorders. In accordance with Eisenberg's[3] studies and observations of these problems, we adhered to his two-dimensional program of stimulant drug therapy (methylphenidate) and supportative psychologic guidance. Our experience with more than 100 children diagnosed as hyperkinetic or lethargic, with associated malfunction of neurologic integration, cooroborates his optimistic conclusions that at least two-thirds or more[4] of these individuals show dramatic response by these methods. With a purported incidence of 10 to 20 per cent of the school population having learning or perceptual disorders, the promulgation of such a practical, expeditious approach to therapy, within the milieu of private medical practice, seems warranted.

METHOD OF STUDY

At the outset, children with these problems received a complete physical examination, covering all aspects of muscular, metabolic, and neurologic functioning. Significant areas in the history pertaining to prenatal, natal and perinatal incidents, as well as serious infections, were evaluated. It was our intention to screen out those children with overt symptoms or signs of brain damage, or whose history strongly suggested factors significant in the etiology of organic brain involvement. Neurologic consultations and EEGs were not routinely secured.

Psychologic evaluation was then carried out by the psychologist co-author. Psychologic tests included the Wechsler Intelligence Scale for Children (WISC), the Bender Gestalt, Frostig, figure drawing tests, and various standardized academic achievement tests, to determine grade-level functioning. Where indicated, personality tests (Rorschach, Thematic Apperception Test (TAT) were employed. Tests of laterality, stereogenosis, and visual and auditory perceptual tests (modified from Birch) were also included. Family imbalance and neurotic interaction were investigated, as well as inappropriate disciplinary management. Awareness of the strategic relevance of the family dynamics was a crucial aspect of the diagnostic and remedial program, as also stressed by Eisenberg.[3] It should not be inferred that, within the psychologic dimension, a prolonged, intensive program of psychotherapy was deemed inevitable. On the other hand, short-term supportive guidance proved to be practical, and entirely adequate.

In our study, methylphenidate was exclusively prescribed in doses ranging from 2.5 mg. twice daily, morning and noon, in the preschool child, to up to 20 mg. or more in the post-pubertal individual. The drug was initiated with relatively smaller doses and then gradually increased by small increments over a period of a week or two, in order to ascertain any evidences of intolerance or adverse side-effects. As treatment pro-

CHART

Methlyphenidate Dosage Schedule For Children With Faulty Neurologic Integration With Perceptual Disorders (Minimal Cerebral Dysfunction)

Age	Dosage
3 - 6 years	2.5 mg a.m. and noon for 3 days, then 5.0 mg a.m. and noon for 3 days, then 7.5 mg a.m. and 5 mg at noon, and then continued as directed.
6 - 12 years	5 mg a.m. and noon for 3 days, then 10 mg a.m. and noon for 3 days, then 15 mg a.m. and 10 mg at noon, and then continued as directed.
12 - 18 years	5-10 mg a.m. and noon for 3 days, then 15 mg a.m. and noon for 3 days, then 20 mg a.m. and noon, and then continued as directed.

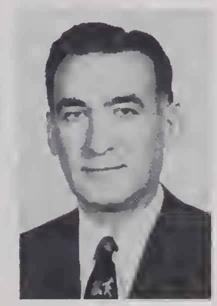
gressed, continuing contact with the mothers prevailed until a requisite dosage level was established, capable of eliciting an optimum behavioral and cognitive efficiency. Bimonthly follow-up visits were routinely recommended. The relative absence of adverse side effects with this drug permitted its uninterrupted utilization over prolonged periods.

A survey in detail of each of our cases would be inappropriate in an article of this type. However, consideration of a few representative cases might clarify our procedures in the effective management of youngsters with perceptual disorders.

CASES

1. L. P. MALE, first seen at six years, four months of age. From infancy he had manifested extreme hyperkinesis, motoric and verbal, with disruptive behavior in kindergarten, home, and neighborhood. Impulsivity, awkwardness, and accident-proneness were present. All the usual management techniques were inadequate. The WISC revealed the following: Verbal IQ 135, Performance IQ 115, and Full Scale IQ 128 (very superior range). The most striking feature of Wechsler functioning in this very bright boy was the marked discrepancy between the Verbal and Performance IQs as noted. Visual perceptual disturbances were strongly evident. The Bender Gestalt test showed poor quality, lack of control, impulsivity, and perseveration.

CO-AUTHORS



NICHAMIN

BARAHAL

Doctor Nichamin is senior attending pediatrician at Children's Hospital of Michigan, Detroit; assistant clinical professor of pediatrics at Wayne State University Medical School, and in private practice of pediatrics. Doctor Barahal is professor of educational and clinical psychology at Wayne State University, psychological consultant to several school systems, and a member of the Michigan Commission of Certification of Psychologists.

Physical examination revealed normal growth and development for his age, with no organic basis for his overt hyperkinesis. Short attention span, inappropriate and irritating conduct, and excessive verbalization were prominent characteristics observed in the office. There were no relevant factors in the prenatal, natal, or perinatal histories; and the past medical history revealed no serious illnesses or accidents. Genetically, it was ascertained that his father had also exhibited a hyperkinetic profile.

Methylphenidate therapy was instituted. With the establishment of the appropriate dosage level, both parents and teachers reported an immediate complete reversal of the hyperkinetic pattern of behavior. He became amenable to ordinary school routines. His academic achievements were finally compatible with his superior IQ. Motor coordination, fine and gross, approached the normal. This was confirmed by actual samples of pre- and post-therapy written work. The family climate was then significantly altered beneficially. In this case, no further psychologic assistance or supportive tutoring was required.

2. M. A. MALE, AGED SIX, had evidenced a moderate degree of hyperactivity, restlessness, short attention span, with poor coordination, during the preschool years and continuing into kindergarten. It was our opinion that the hyperactivity would have been much more apparent during these years had the parents been more permissive. They had set strict limits for the child towards acting-out and unacceptable behavior; and had established considerable structuring in his management. However, in a normal kindergarten milieu, the above-mentioned symptoms were triggered off and made more manifest. His physical growth and development from early infancy had been completely normal. There were no significant factors in the birth or past medical history.

On psychologic testing at the age of six years and two months, he scored as follows on the WISC: Verbal IQ 116, Performance IQ 111, and Full Scale IQ 115 (bright-normal range). The one significant drop in functioning occurred on the

Coding subtest where he manifested disturbed visual-motor-perceptual functioning. His Bender Gestalt reproductions were immature, with poor organization; and he revealed considerable difficulty with touching and overlapping parts and angulation. Ocular pursuit in reading was exceedingly poor, as evidenced by an inability to follow along a line or pursue a visual object. Reading and word-attack skills were non-existent, despite his high intelligence. His behavior throughout the testing suggested the presence of a perceptual disorder with faulty neurologic integration.

Soon after the dosage of methylphenidate was stabilized at 20 mg. daily, hyperactivity, distractibility, and restlessness were decreased markedly. The child now seemed amenable to the learning process.

Supportive reading tutoring was begun once weekly. School functioning improved dramatically. Achievement levels, as measured by the Metropolitan Achievement tests, revealed within less than a year, that he was performing above grade level. His current report card is completely confirmatory of his educational progress, with outstanding ratings in following directions: listening, respecting authority and property, and spelling. Parental attitudes have been transformed from frustration and anxiety into a more approving acceptance of their child and his progress. Their elation with this "new child" has been most rewarding, and has been reflected in a more wholesome, optimistic, and tension-free family climate.

3. D. H. WAS AN ADOPTED MALE CHILD who came under our health supervision at the age of nine and one-half months. There were no relevant factors in the medical or developmental histories. There had been parental preoccupation with bowel evacuation, as well as a multiplicity of minor complaints involving accidents or infections. These factors tended to obscure a basic hyperkinetic pattern that reached an acme at the age of three years. Marked distractibility, hyperkinesis, low frustration tolerance, and temper tantrums then became more apparent. Disciplinary techniques failed to alter the boy's unacceptable behavior. The parents sought relief from an intolerable, chaotic home atmosphere.

On the Stanford Binet Intelligence Scale the child achieved an IQ of 125, which placed him in a very superior category. His extremely immature behavior belied his high intelligence. He also revealed marked perceptual deficiencies, as evidenced in the perceptual-motor tasks. Both on the Binet and Winterhaven gestalts his performance was erratic and considerably below the expectations for his age group. Throughout the testing he manifested restlessness, hyperactivity, impulsivity, and an inability to cooperate. No additional tests were attempted because of his distractibility. He showed particularly strong capacities in verbal and abstract reasoning ability. His draw-a-person was inferior and immature. Copying of simple designs was totally inadequate. Performance on the mazes was replete with impulsiveness, poor judgment, and fine muscle incoordination.

After methylphenidate was introduced, a complete metamorphosis in the child's behavior occurred. Gloom and doom in the family environment were replaced by acceptance and serenity. At certain times the parents reported a brief spell of a peculiar lethargy and mild disorientation. Such incidents had been previously noted in a small percentage of our cases. Usually this aberrant reaction disappears upon a temporary (one week) withdrawal of the drug, followed by reinstitution at low levels of dosage, and then gradual increase to former levels with smaller increments than previously employed.

COMMENT

Emphasizing the use of methylphenidate in perceptual disorders need not be construed as a laissez-faire approach to all learning and behavioral deviations. Definitive pediatric and psychologic diagnosis of this entity of faulty neurologic integration is the sine qua non for effective results with it. Clear-cut evidence of the syndrome must be pinpointed through careful clinical observations and requisite psychologic testing.

There is no gainsaying that, at the very outset, a thorough physical and neurologic examination is the physician's responsibility, and recourse to specialized consultation (ophthalmologic, auditory, speech, EEG, etc.) is mandatory when indicated. In evaluating family histories, we have been strongly impressed with the predominance of genetic factors relating to this syndrome. Promiscuous use of this drug for a variety of school and behavior disorders, without a definitive diagnosis, would be shortsighted and inappropriate.

Early identification and diagnosis is possible, even at the pre-school level. A preventive program for private practice has been presented by one of us (S. J. N.).[5] In fact, federal financing has been approved for surveying this age group for potential perceptive and learning disabilities (Oak Park, Michigan, Board of Education). Early detection of the syndrome is also stressed by Boelsch.[6] During the preschool period, as well as in early infancy, awareness of the hyperkinetic syndrome can afford the opportunity of longitudinal observation and consequent earlier definitive diagnosis and drug administration. Such early drug therapy, with its consequential beneficial effect, can forestall serious ego damage to the child. Untreated, such a child would develop a depreciated self-concept and patterns of desperation and defeat. Likewise, a chaotic family ego disorganization can be ameliorated before cumulative damage is perpetuated. Intensive psychotherapy and miscellaneous lengthy perceptual-training exercises can be avoided.

The physician should carefully prescribe the drug dosage on an individual basis. The accompanying chart can serve as a useful guide, but gradual increases in dosage, up to twice the basic dose, may be necessary with growth or at times of stress. No change or improvement in the child's functioning or behavior is discernible until appropriate levels of dosage are attained.

Medication must be of a continuing nature and should not be omitted on weekends and vacation periods. The omission of even a single dose of the medication on a given day becomes readily apparent to the child himself, as well as to his parents and teachers. In some patients the effect of the drug given at noon is lessened or lost by late afternoon; parents then note a regression to former immature behavior patterns. The situation can be remedied by administering a small (2.5 mg. or 5.0 mg.) dose of the drug at such times.

SUMMARY

Based on our experience in private practice with more than 100 cases of faulty neurological integration with perceptual disorders, a two-dimensional, medical-psychological and pragmatic approach to therapy is presented, employing methylphenidate as the drug of the choice.

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Marked Eosinophilic Response to Combined Chlorpromazine and Trifluoperazine Therapy

BY MELVIN J. REINHART, M.D.
MARTHA STEPHENS, M.D.
ANN ARBOR

While it is generally known that mild to moderate eosinophilia can be representative of responses to allergens, be they dietary, inhalant, or drug, a review of the medical literature for the years 1960 through 1967 reveals only two reported cases of eosinophilia during therapy with psychotropic drugs. Joynt and Clancy report[1] in 1961 an eosinophil count of 61 percent in a patient receiving imipramine therapy with a total white blood cell count of 30,000. The blood elements rapidly returned to normal following a discontinuation of the medication. In 1964 Bacon[2] reported a case of leucocytosis with an eosinophilia of 41 percent during therapy with chlorpromazine, which likewise returned directly to normal upon discontinuation of the medication.

Our case represents, to the best of our knowledge, the first significant eosinophilic response to the combined chlorpromazine and trifluoperazine regimen which is so frequently used in treating psychotic patients.

CASE REPORT

The patient is a 40-year-old Caucasian female; a housewife who was hospitalized at the Neuropsychiatric Institute on November 17, 1967. She had expressed self-destructive and murderous thoughts toward family members prior to her admission.

The initial psychiatric examination revealed a moderate degree of agitation in a depressed woman. The other significant findings indicated she was probably experiencing auditory hallucinations. The physical examination revealed no particular physical abnormalities with the exception of a cystic enlargement of the left ovary felt to represent a functional ovarian cyst. The admission laboratory studies were all within essentially normal limits including a total white blood cell count of 8,400 with a differential cell count of 47 percent polymorphonuclear neutrophils, 45 percent lymphocytes, 8 percent monocytes, and zero percent eosinophils and basophils.

In order to treat her anxiety symptoms, she was begun on chlorpromazine, 200 mgs. per day on the day of her admission, (11-17-67) and this was increased by November 30, to 600 mgs. per day. On that date trihexyphenidyl hydrochloride, 2 mg. per day, was added to counteract extrapyramidal symptoms which were in evidence. Because the aforementioned drug regimen was inadequate to control the degree of agitation, trifluoperazine was added, 6 mgs. per day on December 6, concomitant with an increase in the trihexyphenidyl hydrochloride to 4 mgs. per day. From December 1, through 4, the patient complained of recurrent frontal headaches, which were relieved by Fiorinal and aspirin. A white blood cell count reported on December 4 was read as 13,700. On December 6 complaints of malaise, nausea, and weakness in the lower extremities were reported in addition to a single episode of emesis. The patient reported chills and diarrhea on December 7 with a temperature elevation to 100° orally noted. The white blood cell count reported on December 8, was 17,000 with a differential cell count of 58 percent polymorphonuclear neutrophils, 18 percent lymphocytes, 2 percent monocytes, 22 percent eosinophils and zero percent basophils. The repeated white blood cell count on December 11, was read as 25,100 and four days later on December 15,

GENERIC AND TRADE NAMES OF DRUGS

Chlorpromazine — Thorazine
Trifluoperazine — Stelazine
Trihexyphenidyl hydrochloride — Artane

Both authors are associated with the Neuropsychiatric Institute at the University of Michigan Hospital.

22,400 with a differential cell count of 15 percent polymorphonuclear neutrophils, 19 percent lymphocytes, 2 percent monocytes, 63 percent eosinophils and 1 percent basophils. The patient had been treated symptomatically with Kaopectate, paregoric, and tincture of belladonna to counteract her gastrointestinal symptoms. However, these symptoms did not respond to the antidiarrheal medication, bedrest, and liquid diet.

Upon receipt of the report of December 15 indicating a 63 percent eosinophilia with a white blood cell count of 22,400 the patient was transferred to the Internal Medicine Service with a suggestive diagnosis of parasite infestation. On December 16, the chlorpromazine had been decreased to 300 mgs. daily and on December 18 chlorpromazine, trifluoperazine, and trihexyphenidyl hydrochloride were discontinued. The total white blood cell count and eosinophil differential remained elevated with a total peripheral eosinophil count of 12,028-per-cubic milimeter. By December 21 the white blood cell count had further dropped to 12,100 with a differential cell count of 34 percent eosinophils. The patient's diarrhea had ceased by this time. The diagnostic studies completed on the Internal Medicine Service included a sigmoidoscopy with rectal biopsy, a barium enema, and numerous stool examinations, all of which were reported as being normal. An upper G.I. series revealed a small hiatus hernia. A bone marrow examination demonstrated an eosinophilia of 28 percent with mature cells. Chest film, hemoglobin, and hematocrit were normal. Electrophoresis manifested a slight elevation of total protein and alpha two globulin. Liver function studies always remained within normal limits. The patient was essentially asymptomatic from a physical point of view when she was transferred back to the Psychiatric Service on December 22, 1967. The total white blood cell count on December 27, 1967 was 8,000. The counts have remained essentially with-

TABLE 1

Composite of Serial Hemograms

Reported	Total W.B.C.	P.M.N.	Lymph	Mono	Eosin	Baso	Hgb grams	Hct	Alk. Phosphatase K.A. units	SGPT units
11/20/67	9,900						16.5	47	6.9	13
11/24/67	8,400	47	45	8	0	0	15.6	44	7.5	13
11/28/67	9,400									
12/ 4/67	13,700									
12/ 8/67	17,000	58	18	2	22	0	15.3	43.5		
12/11/67	25,100									
12/15/67	22,400	15	19	2	63	1				
12/18/67	26,000	26	13	3	58 12,028 (total eosin.)	0	16.3	48		
12/21/67	12,100	37	26	3	34					
12/27/67	8,000									
1/ 2/68	10,500									
1/ 5/68	11,300	59	28	10	3					
1/15/68	14,100								7.4	7
1/19/68	10,800	57	38	4	1					
1/22/68	8,700									
2/ 2/68	8,900	41	44	10	4					

in normal limits, subsequently, with the differential cell count repeated on three occasions within normal limits.

COMMENT

The above mentioned case was reported to highlight the possible association of eosinophilia with combined chlorpromazine and trifluoperazine therapy. Unfortunately, the implication of trifluoperazine is somewhat in doubt. One hemogram was completed two days after the initiation of trifluoperazine. At the time of its initiation, the white blood cell count had already been elevated on December 4, 1967 to 13,700. However, no differential cell count was done at that time. One could speculate that the eosinophilia had begun prior to the beginning of the trifluoperazine. However, in view of the relative infrequency of reported cases of eosinophilia with even chlorpromazine, the authors felt that this material should be called to the attention of the readers.

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Editorial Comment:

One wonders in view of the gastro intestinal symptoms what a trichmilla skin test might have shown.

Information for Contributors

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan.

2. Submit original, double-spaced typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

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12. It is understood that material is submitted for exclusive publication in MICHIGAN MEDICINE.

Michigan Department of Corrections Explains School - Pass Program

The Michigan Department of Corrections has inaugurated a new program in correctional education in this state which you should know about because of your interest in civic matters.

This new program is called a "Study-Pass Program" and offers to carefully selected and qualified inmates of Michigan prisons, an opportunity for advanced technical or academic training by attending classes on the campus of nearby community colleges or state universities.

Chief purposes are to help these men test their ability to do acceptable college-level work and to assist them in making a beginning on a college course so that their training is more apt to continue when they return to the communities. In addition, the program opens up opportunities for special or advanced training which are not available at the correctional facilities.

THE BASIC RATIONALE for this new program involves the following:

1. Many men in prison have special aptitudes and skills for which there are no institutional programs because these are too expensive to equip and staff. These programs do exist in the community and it seems practical and wise to take these men to them.
2. There are many men in the prison population who have both the intellectual ability, the interest and the academic background for college-level work. Most of them have not been aware of this and, therefore, have not thought seriously about the possibilities of attending college. They represent a sizable, untapped, human potential which should be made available to society.
3. The Federal system and one or two other states have experimented successfully with this type of a venture and their experience has been used as a foundation.
4. Successful experiences of this kind should do a great deal to improve the image that these men have of themselves and help them to see themselves as more worthy persons.

THE DETAILS OF the plan are:

1. The participants are carefully screened for evidence of intellectual, academic or technical aptitude and a sincerity of interest in the training available.
2. Only those men who are fairly close to release on parole and who do not constitute in any way a menace to the students at the college or to the community generally, would be approved.
3. The participants must have demonstrated dependability and responsibility which would merit their enrollment in this kind of a program.
4. They are transported from the institution each morning to the campus where they are on their own like any other student during the day and are picked up in the late afternoon and returned to the institution.
5. They are required to follow all the college regulations which apply to the other students and, in addition, have certain understandable restrictions on their activities from the standpoint of the Department of Corrections.
6. College credits earned are available for transfer to other colleges and universities where the student may wish to continue in his work when released from the institution.

Financing is taken care of in several different ways. First, if the student or his family have sufficient financial resources he pays his own way. Second, some are eligible for assistance from the Division of Vocational Rehabilitation or under the GI Education Benefits. Third, a modest Tuition Loan Fund has been established by the Department through donations and gifts from interested citizens and is available for men who have no other resources. They draw from this fund on a loan without interest and repay from their income after release.

At the present time, the following colleges are cooperating in the program and have students on the campus: Montcalm Community College, Jackson Community College, Lansing Community College, and Northern Michigan University.

Those men presently engaged in this program have demonstrated college ability and represent a very important human resource in this state which might otherwise be wasted. □

A Case History:

The Payoff Is Rehabilitation

BY C. ARTHUR HAKENEN, CHIEF,
DISABILITY DETERMINATION SERVICE
DIVISION OF VOCATIONAL REHABILITATION
STATE DEPARTMENT OF EDUCATION

Much has been written and said about vocational rehabilitation programs. One of the primary areas of concern is that of the costs involved.

That the costs of such programs can, in some instances, be the least expensive way out for the taxpayer can best be understood with a specific example.

A neurologist's report in July of 1959 had this to say about Mr. H., age 37, after his cerebral vascular accident.

CASE HISTORY

"Spinal puncture revealed bloody xanthochromic fluid indicative of preceding subarachnoid hemorrhage. Bilateral carotid angiography showed a small vestigial aneurysm at the intracranial bifurcation of the carotid on the right and a very large bilobular aneurysm at the same location on the left with some evidence of hemorrhage into the left frontal lobe. . . .

"This patient has made a good immediate recovery from his very serious condition, but I am afraid that the partial ligation of the carotid is, unfortunately, no safe guarantee against further blow-outs; besides, the hemorrhage had been severe enough to cause considerable neurological deficit, which may not clear up completely in the future. For these reasons, I believe that this patient will unfortunately not be able to return to his former job and his outlook as to the future must remain quite guarded."

In April, 1960 checkup at the medical center showed residual mild sensory-motor deficit in the right-sided extremities and marked dysphasia. Prognosis remained guarded.

IT WAS A BLEAK picture for Mr. H., his wife and their four small children. Before the CVA he had been plant superintendent of the tool factory in a small town. Returning to this demanding management position was impossible, because of his frustrating inability to communicate; there was nothing else for which he qualified in his present status. In due course he filed for Social Security disability benefits and his case was evaluated by the Disability Determination Service of the Michigan Division of Vocational Rehabilitation. Mr. H. and his family were found eligible for a grant of $254 a month.

But the Review Physician and the Disability Examiner who adjudicated this claim did not stop there. They also considered Mr. H.'s rehabilitation potential — could he be helped by speech therapy, for example? They decided to refer him to the Vocational Rehabilitation office in his area for evaluation. The new plant superintendent also sought out the VR Counselor, to enlist his help in getting this valued employee back to work, in a job within his capacities.

Mr. H. had something in his favor: He was strongly motivated, although intermittently depressed by the CVA residuals which had diminished his value in the labor market; he had the understanding support of his wife and her interest in the rehabilitation plan.

Although the dysphasia was a formidable barrier, the VR Counselor was encouraged by the current psychological and neurological evaluations and arranged speech training at the medical center. Subsistence expense while in training was shared by the employer through his insurance coverage, the agency and the family.

DURING THIS two-and-a-half-year training period, the Counselor had many conferences with plant officials to discuss progress and employment prospects. In December, 1961 the Counselor asked the company for two sets of the pneumatic hand tool it manufactured — one completely assembled, made up of 41 small parts and the housing — and the other unassembled. He took the two sets to the occupational therapist at the medical center; between them they worked out a plan for Mr. H. to practice assembling the tool, just as it was done on the company assembly line.

Mr. H. worked hard on his speech training and tool assembly and in October, 1962 the Counselor suggested a two-week tryout in the plant. The test was successful and Mr. H. returned to work on a full-time basis as an assembler at $80 a week. He was given a twelve-month trial work period (the maximum), to test his ability to work without loss of benefits — an incentive built into the program to encourage rehabilitation. The benefits stopped in October, 1963.

The Counselor and I visited Mr. H. at his home — he was on vacation — in May, 1968 and found he was still working as assembler and happy with it. He has had several pay increases. Mr. H. still has some difficulty with writing, especially the small words; when he speaks, he has to reach occasionally for the right word. His wife, a registered nurse, told us he had made a good adjustment to working in a lesser capacity. The aneurysm on the right is still there, encased in scar tissue, but he has had no medical problems and gets a checkup every year.

WE STOPPED AT THE factory and visited with the plant superintendent and the foreman. Mr. H. has an excellent production record, we were told, and is considered a superior employee. Because of his management know-how before the CVA they would like to give him more responsibility and discussed this prospect with Mrs. H. She prefers to wait until he is ready for it.

The total cost for VR services provided came to $2,248. Now, let's take a look at the return from this investment in rehabilitation: Had Mr. H. remained idle he would have continued to draw benefits from the Social Security trust fund — $14,732 from October, 1963 through July, 1968. Actually, the amount would be considerably higher because of several increases in cash benefits enacted by Congress. In addition to this substantial saving to the trust fund Mr. H. became a self-supporting taxpayer again, and what this meant to him and his family cannot be measured.

SOCIAL SECURITY TRUST FUNDS

A 1965 Social Security amendment makes money available from Social Security trust funds to finance the rehabilitation of selected beneficiaries — those with the potential to return to productive work through VR services. The amount so released each year to the State Agencies may not exceed one per cent of the total amount paid nationally in disability benefits the previous fiscal year. For the year ending in June, 1968 Michigan received $484,224 in trust fund money.

During this period these Social Security funds made it possible for our agency to rehabilitate 362 beneficiaries, who might not have been served otherwise because of state budget limitations. The average cost for each rehabilitation was $1,108; if we use the national average for payments to each beneficiary and his dependents — $175 a month — Social Security will get back its money in less than a year of employment. We also have 1,051 clients on our active caseload, whose rehabilitation is in process.

THE JOBS OUR CLIENTS entered into were a cross section of Michigan occupations, unskilled to highly technical. Their weekly pay ranged from $40 (cafeteria helper) to $150 (automatic valve grinder). Rehabilitation services included counseling, medical treatment to correct or reduce the disability, prostheses, vocational training at various levels and job placement help.

There will be more trust fund money available for rehabilitation in the future. In Michigan, for example, the disability payments total in February, 1968 was running $6,845,447 a month; this was going to 45,063 disabled workers, their 7,405 spouses and 24,991 children. While this represents substantial buying power, a regular paycheck will bring in more for those with rehabilitation potential. The Social Security-Vocational Rehabilitation partnership wants to help more people get back to work. Rehabilitation costs money, but it pays. ☐

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

William M. LeFevre, M.D., Muskegon, has retired from 43 years of private practice in Muskegon to become plant physician at DuPont in Montague. For 10 years a councilor of the MSMS 11th District, Doctor LeFevre continues active in MSMS, serving as chairman of the MSMS Diabetes Committee, member of the MSMS Beaumont Memorial Committee, and advisor to the Committee on History. He is known to many as the first president of the Michigan Association of the Professions, past president of Michigan Diabetes Association, and past president of the Muskegon County Medical Society.

Wesley G. Logan, M.D., Hastings, has been appointed to the 10-member vocational service consultative group of Rotary International. He has served as a past president of the Rotary Club of Hastings and as a district governor of Rotary International. He is an alternate delegate from the Barry County Medical Society to the MSMS House of Delegates, a past president of the Barry County Medical Society, and chief of staff at Pennoch Hospital, Hastings.

C. A. Dickinson, M.D., Wayland, a past president of the Allegan County Medical Society, has ended 35 years of private practice to become medical director of the Allegan County Health Department. He has served as coronor and medical examiner since 1935.

Robert E. Bogue, M.D., Detroit, is currently president of the Michigan Society of Obstetrics and Gynecologists. President-elect of the Society is Joseph B. Woolfenden, M.D., Grosse Pointe. Serving as treasurer is John M. Malone, M.D., Detroit, and as secretary, Joseph J. Woods, M.D., Ypsilanti.

Hilliard Jason, M.D., East Lansing, discussed the educational philosophy and curriculum innovations of the Michigan State University College of Human Medicine in Helsinki, Finland, at the meeting of the 17th General Assembly of the International Federation of Medical Student Associations. Doctor Jason is director of MSU's Office of Medical Education Research and Development.

James G. Christopher, M.D., Hamtramck, has retired from his post of chief pathologist of Holy Cross Hospital, Hamtramck. He had been associated with the hospital since it opened in 1946. At different times, Doctor Christopher has been a member of the medical faculty at the University of Vienna, Wayne State University, and the University of Detroit Dental School.

Kenneth E. Pitts, M.D., Grosse Pointe, associate professor of psychiatry at the Wayne State University School of Medicine, is supervising a graduate training program in psychiatry, to be continued through a recent grant of $71,623 from the Public Health Service.

Allen B. Moore, M.D., Essexville, has accepted a position as assistant medical director of the International Harvester Company, Chicago. He resigned from the Saginaw Valley College Board of Control to which he had been appointed by Governor Romney.

Samuel T. Sandell, M.D., Houghton, was feted at a retirement dinner by his colleagues of the Houghton, Keweenaw and Baraga County Medical Society. Former head of the Copper Country Tuberculosis Sanitorium of Houghton and Hancock, he will retire in Duluth.

Norman Harebottle, M.D., Fowlerville, and family were bade farewell at an open house given by the Lutheran, Baptist, Catholic and Methodist ladies societies of Fowlerville. After 10 years in the community, the family is moving to Tempe, Arizona. Doctor Harebottle is a former president of the Livingston County Medical Society.

Robert E. O'Connor, M.D., Detroit, has been appointed to the newly-created position of Director of Clinical Development for Parke, Davis and Company. Doctor O'Connor, who will review and evaluate plans and clinical studies for new drugs and explore new applications for marketed products, joined Parke-Davis in 1963 after practicing in California. He obtained his M.D. from the University of Illinois.

Community Health Week, October 20-26

Every county medical society in Michigan is urged to develop appropriate programs marking the annual observance of Community Health Week, October 20-26 and to encourage other members of the community health team to join with them in planning and carrying out activities.

The purpose of Community Health Week (October 20-26) will be to focus public attention on the dramatic advances which have occurred in medicine and health care. The Annual Community Health Week project is proclaimed by the AMA and MSMS to stimulate a greater public understanding of the growth, high quality and availability of health resources and facilities within the individual community.

The 1968 Community Health Week this fall will focus attention upon (1) the growing problem of drug abuse, (2) the need to encourage and support the programs encompassing physical fitness, and (3) the expanding, urgent need for young men and women to train for medical and allied health careers.

Each county society has been urged to organize a health careers recruitment program. Doctors can speak to school assemblies, can consult with school counselors, can cooperate with the medical auxiliary and voluntary agencies, etc.

As in other years, the Michigan Health Council and the Michigan Association of the Professions will jointly sponsor Community Health Week with MSMS.

FOR BETTER MEDICAL CARE
A UNITED HEALTH TEAM

MSMS-MHC to Sponsor Careers Workshop Oct. 23

A special health careers conference will be held October 23 near Battle Creek for representatives of county medical societies, hospital board members, hospital administrators, school counselors, community college officials, county supervisors, nurses, and all others interested in health manpower.

The theme will be "Health Manpower Is a Community Affair."

The one-day meeting will be held at the pleasant Michigan Education Association Conference Center on St. Mary's Lake. The MSMS Committee on Rural Medical Service and the Michigan Health Council will sponsor the workshop. Robert E. Rice, M.D., Greenville, the program chairman for the event, is chairman of both the MSMS Committee on Rural Medical Service and the MHC Professional Placement Committee. Major speaker will be Milford O. Rouse, M.D., Texas, past-president of the AMA.

The agenda will cover the following topics:

Health Manpower
Role of the Community College
Role of the University
Role of the Community Hospital in health care programs
Progress report on MHC manpower study in Southwestern Michigan
Role of Voluntary Health Councils

All interested MSMS members are invited to attend, and a special appeal has been made to every county medical society president to send several representatives.

The conference will be one of several Community Health Week features.

Hearing-Speech Conclave Soon

Medical personnel interested in ear problems and those working with very young children will want to clear their calendars for Friday, September 27.

Marion P. Downs, director of clinical audiology at the University of Colorado Medical Center, Denver, will speak on "Identification of Hearing Impaired Infants" to open the Michigan Association of Better Hearing and Speech convention at the Pick-Fort Shelby Hotel, Detroit.

Mrs. Downs, an instructor in surgery in the University's otolaryngology division, is a consultant to the ENT department at Fitzsimons Army Hospital.

Theme of the convention will be "Early Identification and Habilitation of Hearing Impaired Children."

Royal C. Hayden, Jr., M.D., Detroit area otologist and director of the Otological Research Laboratory at Henry Ford Hospital, will be Friday chairman.

Urge Every MSMS Member Attend September 25-26

House to Install Lightbody, Pick Other Leaders

The election of the MSMS president-elect will be one of the highlights at the House of Delegates meeting in Sheraton-Cadillac Hotel, Detroit, September 22-25. The elections will be Tuesday night, September 24.

Four Delegate and Alternate Delegate posts to the AMA will also expire and be open for election. Current incumbents in these positions are: Delegate — Sidney Adler, M.D., Detroit; George W. Slagle, M.D., Battle Creek; Donald N. Sweeny, Jr., M.D., Detroit; Joseph A. Witter, M.D., Highland Park; Alternate Delegate — James C. Danforth, Jr., M.D., Detroit; John J. Coury, M.D., Port Huron; Marjorie Peebles-Meyers, M.D., Detroit; and Vernon V. Bass, M.D., Saginaw.

Terms of office for MSMS Councillors Milton R. Weed, M.D., Grosse Pointe Park (1st District), John J. Coury, M.D., Port Huron (7th District), A. Carl Stander, M.D., Saginaw (8th District), Edward H. Rodda, M.D., Bay City (10th District), Eugene R. Elzinga, M.D., Marquette (12th District), and Robert J. Mason, M.D., Birmingham (15th District) will expire this year.

Elections also will be held for the speaker and vice-speaker of the House of Delegates.

James J. Lightbody, M.D., will be installed as new president of MSMS at a delegate dinner meeting in the Book Casino.

The elections will cap three days of work by the House of Delegates, beginning on Sunday, September 22, at 6 p.m. with reference committee chairmen gathering for the Speaker's Dinner.

The Speaker's Dinner will be followed by the first meeting of the House of Delegates. Gerald D. Dorman, M.D., AMA President-Elect, will bring greetings to the delegates. Also speaking at that time will be MSMS President Bradley M. Harris, M.D., and President-Elect James J. Lightbody, M.D.

Other highlights of the first meeting of the House will be the report of the committees on Certificates of Commendation and Michigan's Outstanding Physician.

Delegates will consider resolutions and reports Monday and Tuesday. The Fifty Year Awards will be given Tuesday.

Sheraton-Cadillac Lifting Its Face

The Sheraton-Cadillac Hotel, looking forward to the MSMS Annual Session and other fall conventions, has just completed the first stage of a $4,000,000 renovation and improvement program.

Four hundred guest rooms and suites have been redecorated and refurnished, with plans to complete the remaining 800 rooms in the next year.

One million has been spent already for new, high-speed automatic elevators.

The hotel is currently in the process of replacing all windows on the first six floors, and eventually, throughout the hotel.

Tentative plans for a $8,500,000 addition to the hotel are being developed by Mark Schmidt, vice president and general manager. A 17-story addition will be built adjoining the present hotel, replacing the Detroit Edison building on Washington Boulevard and the Hughes-Hatcher-Suffrin store on Shelby at State. The addition will have 300 guest rooms, a swimming pool, restaurant, and fashionable shops on the ground level. There will also be an underground garage for 350 cars. The ballroom will be expanded to accommodate 1,500 persons.

BEGIN WORK SOON ON UPJOHN CENTER AT ANN ARBOR

Work is to begin shortly on the nation's first university-based research and training center devoted to clinical pharmacology.

University of Michigan officials signed papers this week awarding the $988,714 construction job on the Upjohn Center to Jeffress-Dyer, Inc., of Ann Arbor.

The Upjohn Center was made possible by a gift of $1.1 million from the Upjohn Company.

Cross-Shield Get Okay for New Building

The Detroit Common Council on August 27 approved plans submitted by Michigan Blue Cross and Michigan Blue Shield to purchase property for a new combined service center to be erected on an 11.6-acre downtown urban renewal site north of Jefferson and west of the Chrysler Freeway.

The Detroit City Housing Commission previously approved the transfer of the land and the Detroit Planning Board approved the building plans.

THE CENTER WILL consist of a 22-story administration building and a connecting three-story computer facility costing an estimated $27.5 million.

A five-deck parking garage for 1,262 automobiles which is required under city planning commission zoning regulations also will be built. The garage will cost approximately $2.9 million and will be paid for through parking fees.

Other costs include $1,203,339 for the land, plus site preparation work and architect fees. The complex has been designed by Giffels and Rossetti, Inc.

The computer facility is expected to be completed by April, 1970, and the administration building completed by December, 1970.

Project costs will be shared equally by Blue Shield and Blue Cross.

IN A JOINT STATEMENT, William S. McNary, president of Michigan Blue Cross, and John C. McCabe, president of Michigan Blue Shield, said that a substantial part of the financing will be through mortgage.

"The building program is designed for efficiency and functionalism," McNary and McCabe added. "It has no frills and it does not require any increase in rates.

"The decision was based on a 10-month study by outside consultants which showed that increasing operational difficulties would result from further scattering of operations to meet the growth in our business.

"The study indicated that it is costing Cross and Shield an extra $100,000 a month to do business from fragmented and rental locations.

"The study showed that it would cost us $4.50 a square foot to build as opposed to our present rental costs of $5.57 a square foot.

"We are therefore building to save money as well as building to centralize our operations and improve service to our subscribers and providers of service."

The corporations currently rent more space than they own.

The facilities will include a 300-seat auditorium, to be available for public and professional groups concerned with health care. The site has enough land for an additional building in the future.

Detroit Mayor Cavanagh described the proposed center as a "major step in Detroit's revitalization," and added: "The new Blue Cross - Blue Shield center is a very sizeable addition to downtown Detroit's area redevelopment. It will mean more jobs for Detroiters as the needs for medical-hospital programs increase."

Internists Confer Soon at Gaylord

Specialists in internal medicine in Michigan will hold a scientific meeting in Gaylord, September 20-21, under the auspices of the American College of Physicians (ACP).

Special guest at the meeting will be H. Marvin Pollard, M.D., ACP President, and professor of internal medicine at the University of Michigan Medical School.

The meeting at the Otsego Ski Club is under the general direction of Muir Clapper, M.D., Detroit, ACP Governor for Michigan and Professor of Medicine, Wayne University College of Medicine.

The new Michigan Blue Cross and Blue Shield combined service center will look like this architect's model. At left is the five-level parking garage, with the administration building in the center, at the corner of St. Antoine and Lafayette East. The computer facility, with separate humidity and air cleaning and conditioning controls required by its electronic equipment, is at the right.

PAC Breakfast Sept. 25 Offers Conyers, Riegle

MDPAC will hold a congressional breakfast featuring talks by Congressman John Conyers Jr., (D), Detroit, and Donald W. Riegle Jr., (R) Flint, on September 25 at the Sheraton-Cadillac Hotel during the MSMS Annual Session.

Breakfast chairman is George L. Reno, M.D., of Detroit. Assisting him are John Moses, M.D., Wyman C. C. Cole Jr., M.D., Sidney Chapin, M.D., Vernon V. Bass, M.D., and Lionel Swann, M.D.

A special guest at the breakfast will be Mrs. Frank Gastineau, an AMPAC board member from Indianapolis. Tickets for the breakfast, available from MSMS headquarters, are $4.50.

"Ars Medica" Highlight for Annual Session

Throughout the Scientific Session, *Ars Medica*, an exhibition of prints depicting medical subjects, will be on special display at the Detroit Institute of Arts. The collection comes from the Philadelphia Museum of Art, where it is on permanent display.

Established through the generosity of Smith, Kline & French Laboratories, the collection will be on display from September 22 to October 20.

Arrangements were made by the Department of Graphic Arts at the Institute and a committee of Detroit physicians who raised the necessary money for shipping the display.

Oakland University Series on Hormones Open to Physicians

The Third Post Graduate Professional Education Symposium Series sponsored by Oakland University for area physicians will begin Sept. 17.

The series of programs is designed to furnish interns, residents and practicing physicians basic information on hormones and their action along with new knowledge on recent developments in the important field of endocrinology and clinical applications of this knowledge in selected areas of medical practice. All sessions are scheduled 7:30 to 9:30 p.m. in Room 195 of the Science Building.

The first session, Tuesday, Sept. 17, is entitled "How Hormones are Made" by Piero P. Foa, M.D., WSU.

The second session, Tuesday, Oct. 1, "How and Where Hormones Work" is also by Dr. Foa.

On Tuesday Oct. 15, the third session will be held. "New Concepts of Diabetes" is the topic for George C. Gerritsen, Ph.D., The Upjohn Co.

The fourth session will be Tuesday Oct. 29, with William L. Miller, Ph.D. of The Upjohn Co. His subject is "Insulin and Oral Agents."

Session five will be Tuesday, Nov. 12. "Hormonally Active Non-Endocrine Tumors" is the subject for Lawrence Power, M.D., WSU.

"Newer Aspects of Reproductive Physiology" will be the subject for Earl Plunkett, M.D., U. Western Ontario", on Tuesday Nov. 26.

The final session, Tuesday Dec. 10, will be "The Pill and Its Problems" by S. J. Behrman, M.D., U. of M.

NAMED AT SAGINAW

Robert Clowater, M.D., has become the medical superintendent of the Saginaw County Hospital, succeeding retiring superintendent V. K. Volk, M.D. Doctor Clowater was succeeded in his former position as medical superintendent of Muskegon Northshore Hospital by W. Leonard Howard, M.D.

Michigan Men Hear Ideas at PR Seminar

Medicine today faces the task of relating medicine to matters of public concerns, declared AMA President Dwight L. Wilbur, M.D., at the 1968 AMA Public Relations Institute, attended by MSMS leaders in Chicago late in August.

MSMS President B. M. Harris, M.D., MSMS PR Chairman Brock E. Brush, M.D., and Scientific Editor John W. Moses, M.D., led the Michigan physicians and MSMS staff members at the workshop.

Many of the current MSMS projects were displayed in the exhibit room of tested public relations ideas.

In discussing advances in medical sciences and growing government involvement in health care, AMA President Wilbur suggested that the medical profession must focus attention on quality of care and also should become more concerned about the delivery of such care.

There were many speakers — and some urged county medical societies to re-evaluate their functions. It was suggested that county societies "must pause to see where we have been, where we are today, and where we go from here."

MARMP HELPS BEGIN DRUG INFO CENTER

A Drug Information Center has been established at the University of Michigan under a grant from the Michigan Association for Regional Medical Programs, Inc., to act as a rapid, random access, service function to the medical professions of the State. Its goal is to help bridge the gap between the medical professions and the estimated 200,000 articles of medical interest published per year.

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OCCUPATIONAL MEDICINE

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Alternate not elected

OPHTHALMOLOGY

(Not elected)

OTOLARYNGOLOGY

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ORTHOPEDIC SURGERY

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PHYSICAL MEDICINE

(Not elected)

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PROCTOLOGY

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THORACIC SURGERY

None

UROLOGY

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Extract of MSMS Council Minutes

Meeting of July 18-19, 1968

The Council received a report from the Chairman of the Michigan Delegation to the American Medical Association, Luther R. Leader, M.D.

A final report of the Ad Hoc Committee to Study MSMS Relationships with Blue Shield was adopted by The Council and the supplementary comments and suggestions were referred to an appropriate standing committee for study and report. In brief, the Committee recommended that the relationships between Blue Shield and MSMS be continued and communications improved.

CONTINUING PAST POLICY, The Council authorized the inviting of osteopaths to attend the MSMS Annual Scientific Session upon recommendation of component medical societies. The Council enlarged this policy so that all non-member practicing physicians may be invited to the scientific meetings with no registration fee.

The Council authorized MSMS representatives to attend the AMA Annual Communications Institute and Conference of County Medical Society Officers in Chicago and the Second National Congress on Medical Ethics.

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

The Council appointed Norman D. Henderson, M.D., as the MSMS representative to an advisory board of study American Medical Association-University of Michigan chapter. The Council also presented to the Director of Michigan Department of Public Health nominations for the Laboratory Facilities Council.

Speaker James B. Blodgett, M.D., reported to The Council that the Committee on Procedures, of the House, had two major recommendations that introduction of resolutions should be permitted at the first and second meetings of the House only, except by consent of 2/3rds of the Delegates and that the President should be installed at a dinner meeting at the House on Tuesday evening. The remainder of the 61 responses were referred to a committee for study.

THE COUNCIL APPROVED Finance Committee amendments to the MSMS budget reflecting an anticipated increase in income and an anticipated decrease in annual expense, thus increasing the sum available for principle and interest payments by some $13,000.

Regarding the Beaumont Memorial, the Council requested the Beaumont Committee to clarify the legal, financial and moral responsibility that MSMS has to the Beaumont Memorial.

The Council reviewed annual summaries of committee activities which will be presented to the House of Delegates, approved the preliminary report of the Council to the House of Delegates, and reviewed minutes of committees which had met since June 5, 1968.

THE COUNCIL MET WITH representatives of the following groups and organizations: Michigan Department of Social Services; Michigan Health Council; MSMS Judicial Commission; Michigan Hospital Association; and Michigan Medical Service.

The Council received a report from insurance counsel on company representatives re malpractice insurance and referred this to the Professional Insurance Committee for study and report.

Meeting of June 5, 1968

AMA-ERF checks were presented to representatives of the Michigan medical schools by President Harris and Chairman Mason. The American Medical Association-Education and Research Foundation Checks went to Wayne State University Medical School ($6,911), University of Michigan Medical School ($12,203), and Michigan State University College of Human Medicine ($1,317).

The Council received a report from Treasurer John R. Ylvisaker explaining the format of operations for the Board of Managers (which is responsible for the new asset management plan) and reported that the Board had created, as authorized by The Council, a capital reserve account.

THE REPORT FROM Michigan Medical Service was presented by Lewis F. Hayes, M.D., Vice-President, concerning Medicaid experience over a 12 month period, information on analysis of claims experience, variable fee program status and Title XIX underwriting.

In anticipation of future problems, The Council decided to study the desirability of MSMS involvement in contract negotiation and created, therefore, an ad hoc study commission on negotiating contracts for medical services.

The Council authorized MSMS representatives to attend the National Conference on Rural Health sponsored by the AMA, the AMA Congress on Environmental Health Problems, and the AMA Regional Legislative Conference in Chicago.

The Council also authorized distribution of special reports about other state medical society annual meetings to The Council, Delegates and Alternate Delegates to the AMA and MSMS Delegates.

For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

Oscar D. Stryker, M.D., was appointed MSMS representative for planning a workshop on smoking and related disease to be conducted by the Michigan Academy of General Practice in October.

APPROVAL WAS GIVEN to continued MSMS cooperation in the automotive crash injury research program of the Cornell Laboratory, which is continuing its study to evaluate recent automotive design modifications in Michigan.

A. C. Stander, M.D., Saginaw, was appointed as The Council representative to the Michigan Hospital Association convention.

The Council directed that MSMS prepare a response to the proposed actions of the Michigan Community Health Services Study.

The Council favorably approved a request from the American Public Health Association for financial support of its meeting to be held in Detroit. A modest sum was appropriated.

Upon recommendation of the Finance Committee, The Council also approved a grant to finance an education project for the Michigan State Medical Assistants Society.

The Council reviewed the minutes of the many committees of MSMS which had held meetings since the last meeting of The Council.

REGARDING PROFESSIONAL liability insurance, because of rapid developments in this area, The Council requested to the MSMS insurance advisor to prepare a complete report on professional liability insurance prospects and possible advantages of group-sponsored plans with specific recommendations for Council consideration in July.

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

COMING EVENTS

ASIM President To Address Michigan Internists at Gaylord

The Michigan Society of Internal Medicine will hold its annual meeting in conjunction with the American College of Physicians Regional Meeting at Hidden Valley (Otsego Ski Club) Gaylord, September 19 and 20.

On Thursday evening, September 19, R. Gerald Rice, M.D., Director of the Michigan Department of Health will speak on "Comprehensive Health Plannings," and Larry H. Birch, M.D., Director, Regional Medical Programs, University of Michigan Medical Center, Ann Arbor, will discuss "Regional Medical Programs—Past, Present, and Future."

Robert S. Long, M.D., of Omaha, President of the American Society of Internal Medicine, will be featured at the noon luncheon meeting, Friday, September 20. His topic will be "The Efficient Internist."

Arthur W. Strom, M.D., Hillsdale, will be installed as president of the Michigan Society of Internal Medicine, succeeding John R. Caldwell, M.D., Detroit. ☐

Heart Transplant Surgeon To Offer '69 Beaumont Talk

The surgeon who has performed the highest number of heart transplant operations in the world, Denton A. Cooley, M.D., from the Baylor University College of Medicine at the Texas Medical Center in Houston, will deliver the 1969 Beaumont Lecture at the Wayne County Medical Society Building. Doctor Cooley has proformed four human heart transplants.

"The subject of Doctor Cooley's lecture, 'Transplantation of the Human Heart,' says Conrad R. Lam, M.D., chairman of the Beaumont Lecture Committee, "is certainly the most current in the interest of everyone, and its place in the list of Beaumont lectures will add another important milestone in the history of medicine as recorded in the chronology of the lectures."

The lecture is scheduled for Monday, April 7, 1969. ☐

Better Hearing, Speech Convention to Follow MSMS Annual Session

Neonate testing and early rehabilitation of hearing impaired children will be the central theme when Michigan Association for Better Hearing and Speech holds its two-day fall convention at the Pick-Fort Shelby Hotel, Detroit.

Marion P. Downs, a clinical audiologist, who has developed a program of newborn hospital testing, will give the keynote address Friday morning, September 27, at 9:30. Miss Downs, director of clinical audiology at the University of Colorado Medical Center, Denver, has lectured and written extensively on her program which is now used routinely in nine Denver hospitals.

Chairman of the Friday program, planned to be of special interest to doctors, is Royal C. Hayden, Jr., M.D., Detroit area otologist and director of the Henry Ford Hospital Otological Research Laboratory.

G. Fred Moench, M.D., director of the Midland City-County Health Department, is MABHS president. ☐

MEDISCENE

Sept. 4-5 — Conference for Physicians and Nurses, St. Mary's Lake
Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit
Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit
Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit
Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit
Oct. 9 — Family Life Education Workshop, MSMS Headquarters, East Lansing
Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor
Oct. 20-26 — National Community Health Week
Oct. 23-24 — Michigan Tuberculosis and Respiratory Disease Association Annual Meeting, Hayes Motor Hotel, Jackson
Oct. 24 — Michigan Thoracic Society Annual Meeting, Hayes Motor Hotel, Jackson
Oct. 30-31 — Symposium on Neuroendocrinology of Human Reproduction, McGregor Conference Center, Wayne State University
Nov. 6 — The Council, MSMS Headquarters, East Lansing
Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron
Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit
Dec. 1-4 — AMA Clinical Convention, Miami
Dec. 18 — The Council, MSMS Headquarters, East Lansing ☐

To Cos Add "t" from Trouble And It Spells Cost . . .

BY WILLIAM S. McNARY, PRESIDENT
MICHIGAN HOSPITAL SERVICE

Cos is where it all started.

And who knows where it will end.

Cos is a ragged, little Greek island of about 20,000 souls. Not far from the southwestern corner of Asia Minor, the island is the second largest of the Dodecanese, a lovely word to say, in any language.

Hipprocrates, the "father of medicine," was born on Cos about 460 B.C. And it was on Cos that he established the first medical school and the first hospital, as we think of them.

The local folk tell tourists that Hippocrates, the school and the hospital all thrived in the shade of a beautiful plane tree, whose truck now measures 30 feet around and whose immense, gnarled branches must be supported by pillars.

From these beginnings, many wonders have been wrought, as we all know, by what we now call our health care system.

SUCH WONDERS INDEED!

With heart transplants, our physicians — not our philosophers nor our religious leaders — have brought us face-to-face with the stark demanding questions of, "What is life?" and "Who shall have it?" These questions must be answered, and very soon.

Because of the growth of this health care system that benefits us all, we now are in such serious difficulty on the cost question that it is of great national concern. Perhaps health care costs don't rank with racial problems, inflation, poverty, big city crime and foreign involvements, but they're well up the list and have been climbing like a rocket for two decades.

What might be the principal root of this problem that faces all of us has been explained by D. Eugene Sibery, executive director of the Greater Detroit Area Hospital Council. Gene says:

"There is considerable cogency to the charge that we, in fact, do not have a health care system, if by system we mean an orderly arrangement which assures proper interrelationship and coordination between the various components."

The costs racked up by this sprawling health care industry rank as the nation's third largest category of spending (behind food and construction). Worse, it's rising at about twice the rate of the cost-of-living.

THERE CAN BE LITTLE DOUBT that costs cannot continue to climb in this fashion. If permitted to do so, we would be spending, sooner than you think, all of our gross national product on our health. Of course, this cannot and will not be permitted.

A fierce furor already exists about health care costs. Those of us who work in this field have been nervously aware of this for years. The concern now is being expressed everywhere. It's a frequent subject for popular journals. It's a hot topic of common conversation. It draws continual comment from government spokesmen.

At the conslusion of the National Conference on Medical Costs last year in Washington, a most astute and plain-spoken man, John W. Gardner, then Secretary of Health, Education and Welfare, said of our health care system:

"We cannot go on as we have in the past. New patterns will be necessary. Those who entertain some apprehension as to what the new patterns will be, had better plunge in and experiment with their own preferred solution."

Mr. Gardner added something very important: "The aspirations of the American people for health care are apparently without ceiling . . . these vaulting aspirations pose serious problems for those whose task is to achieve the goals. Aspira-

This article, which appeals for "state and local planning to create a voluntary health care system to replace our present uncoordinated, basically inefficient conglomeration of good, fair and poor health care facilities" appeared in the recent Annual Report of Michigan Hospital Service. It is reprinted with the permission of Mr. McNary and MHS. Appreciation is voiced for the use of the illustrations.

tions run into the hard reality of resource constraints."

In a November letter to Gardner, AFL-CIO Pres. George Meany talked even tougher and harder.

MEANY URGED IMMEDIATE, effective controls on doctors' fees. "There is no excuse whatsoever," he said, "for this relentless escalation in physicians' fees, especially those charged under the Medicare program."

Whether his fact base is sound or shaky, a man of Meany's stature and influence does not make such startling proposals without having in his mind a clear intent that could carry the day much sooner than those enraged by his statement may believe possible.

In an interview with the magazine *Medical Economics,* Jerome B. Pollack, professor of the economics of medicine at Harvard and a former Michigan Blue Shield director, said:

"Inevitably, government will play a larger role in achieving a better health system . . .

" . . . The government is in medicine because the public wants it there, and if doctors continue to fight government at every point — even in those areas where government has legitimate interest, such as the welfare of the people — then Washington is just going to take over the whole thing.

"That happened in England and it can happen here. That's what doctors really have to fear."

I THINK JERRY IS wrong about the extent to which the public wants government in medicine.

But if these voices are too political, too shrill, too liberal for you, try this!

Good Housekeeping magazine surveyed 1,000 American women on the way their health care needs are being met. Although the survey asked only for their views on costs, the magazine — which is not given to sensationalism — concluded:

"It (the survey) clearly touched a raw nerve. For women everywhere spontaneously poured out their wide-ranging complaints.

"Whether they singled out excessive dental charges, exorbitant eyeglass costs, soaring hospital bills, incredible surgeons' fees, budget-wrecking prescription costs, welfare chiseling, insurance deficiencies, Medicare failings, callousness of specialists, laziness of hospital personnel or encroachment of socialism into the medical field, (they) revealed an almost bottomless well of discontent."

Because of the discontent, some dractic things have been happening in the field of health care.

For instance, Michigan Blue Cross has had to defend its Hospital Qualifications Program in a legal battle that carried to the State Supreme Court.

TOO FREQUENTLY, WHILE unquestionably acting completely in the public interest, we've been accused of being a monster, of inhibiting free enterprise or of acting dictatorially.

The ogre most frequently used to threaten those who oppose even minor experiments bearing on the cost question is GOVERNMENT MEDICINE.

It's a tired and tattered old scarecrow.

And it's worthless.

It's not that I'm against government. It's just that I don't believe the government can provide a satisfactory solution to this complicated problem.

Medicare and Medicaid in our country and the dractic approaches used by other nations prove that shifting the financing mechanism to another location or jurisdiction means absolutely nothing in terms of effective cost control.

Last November, in the report of the Federal government's National Advisory Commission on Health Manpower, it was concluded (and placed in italics for emphasis):

"Government alone is not big enough to solve the problems of health care for the American people."

EVEN MORE RECENTLY, the Gorham Report (HEW's Report to the President on Medical Care Prices) said:

"The Federal government . . . cannot make a major impact on the efficiency of medical care delivery without the cooperation of the medical profession, the hospital industry, insurance carriers, State and local governments and many other public and private groups."

In such a complicated and emotionally-charged field as health care, the problem has many, many facets. I could, for instance, provoke each of you to argue with some heat and personal application about such statements as:

- There are too many hospital beds . . . and you will cite the recent time when you or someone you know had to wait a week or two to get such a bed.

- Drug research and production are expensive . . . but you want the latest and absolutely best medicine when you need it — and you seem to need a lot.

- Nurses salaries are too low . . . and you'll relate how service was poor and the nurse never was there when you wanted her.

- There are too many small, inefficient hospitals . . . but you don't want to drive even 10 miles twice a week for your mother's radiation therapy — so you fight to save "our hospital" down the street.

- There are not enough doctors . . . but they make too much money, except for your personal physician, who is a fine man, terribly overworked, to whom you say frantically, "Save my daughter; I'll pay anything."

RATHER THAN ARGUE these points (which are, by the way, very pertinent), could I ask you to reflect instead on two relatively simple questions?

The first was suggested by my friend, J. Douglas Colman, president of the New York City Blue Cross Plan.

"It is clinically impossible," he said, "to insulate an individual from the cumulative effects of his own neglect or self-indulgence. Citizens must accept the responsibility to minimize the need for health care."

The truly intriguing question that resulted from dwelling on his comments is:

Can the American individual, through his or her own education and effort, affect the kind of personal control of his demands for health care that will make unnecessary the massive, forced cost controls he seems to be demanding?

Interesting!

Despite the amazing accomplishment of the American people in individually improving their health, the answer probably is, "No." The evidence supports John Gardner's comment that "the aspirations of the American people for health care are apparently without ceiling."

But I'm not so sure.

Perhaps in 10 or 15 years, the current explosion in higher education will produce changes we will find almost unbelievable.

AS WE PROGRESS, can we not expect — with advances in individual health care and with vastly-improved applications of environmental health and preventive medicine, both of which are now beginning to get the emphasis they deserve — some relief in the cost of the treatment of illness?

This is not a fascinating possibility. It's a fascinating probability.

I really do hope that, through education, people will improve their environment and benefit so greatly from preventive medicine that their need for expensive treatment due to sickness or injury will plummet.

We now think of the health care system as providing for people only when they are ill or injured. In many, many instances, this is a "lock the barn door" proposition.

Environmental health and preventime medicine, too long outside the fold of the health care industry, are complicated. They embrace much not now considered a concern of our hospitals and doctors (who have enough to do just treating the sick and injured).

I refer to air and water pollution, mental stress, personal health habits, sanitation in the home, diet and — most of all — education in all such subjects.

But, as responsible realists with a most pressing problem, we must view this happy tomorrow only as an eventual safeguard against our immediate dilemma.

In the meantime, if the answer to the above question really is negative, and if we agree that health care costs cannot continue to increase at the current rate or anything near it, the next question is a tough and disagreeable one.

Who will apply the control, backed by force, required to reduce the increases in the cost of health care to an acceptable level — and how will it be done?

Those in the health care field have worked mightly on cost control. More and more is being done every day. I could fill pages just briefly mentioning these efforts. The box below lists only a few:

- Health facility planning
- Progressive patient care
- Coordinated home care
- Group institutional purchasing
- Eliminating duplication of expensive equipment in neighboring facilities
- Closing of outmoded facilities
- Merging of several small hospitals into a single modern service center
- Shared services, i.e., laundry, X-ray, blood banks, computer services, etc.
- More use of modern management techniques from industry and business
- Better division of labor to reduce routine work by trained specialists
- Greater fee standardization by physicians
- More group practice in its various forms
- Multiphasic screening of patients
- Preadmission testing to reduce lengths of stay in hospitals
- Health education and counseling
- Cost and quality control in hospitals
- Reduction in benefit duplication by prepayment plans and insurance firms
- Incentive payment plans for hospitals and hospital employees
- Flat negotiated fees to hospitals or doctors
- Intensive review and audit of services and costs

Believe it or not, there are large and influential groups of individuals — most of them fine people — staunchly opposed to and working actively against most of the proposals in this list.

And there is widespread public understanding of and support for almost none of them.

LET ME COMMENT BRIEFLY on just the first item — health facilities planning.

Michigan Blue Cross supports health facilities planning through its Hospital Qualifications Program, which I mentioned earlier. It's one of the most potent weapons in our cost control armamentarium to conserve the dollars of our 4½ million members.

The highly-regarded findings of the National Commission on Community Health Services — commonly known as the Folsom Report — said in 1966:

"The rapid rise in the cost of hospital care . . . is a matter of grave concern . . . The Commission takes the position that further increases . . . must not be accepted complacently."

One of its recommendations on cost was:

"Regional health-planning councils should be responsible for initiating and coordinating health facility planning for the region."

Yet, in the next year, the equally-prestigious National Advisory Commission on Health Manpower, said in what is now known as the Miller Report:

"Although there is considerable evidence to support this belief, we are skeptical of the value of giving planning agencies the authority and responsibility to approve or disapprove individual hospital projects . . . We doubt that planning councils will have sufficient objectivity and wisdom to make decisions always in the best interests of the entire community . . ."

Such a divergence of opinion among two groups of top-level national leaders, who studied at great length and presumably had available to them the same information, is difficult to comprehend.

THE QUESTION REMAINS on the table. Who is to control cost and how?

This is not a bitter lament, like those so popular these days with men who wish to appear learned and profound, but who end with a challenge, "It's up to you to do something or the government will."

It should be pointed out that the resolution of the real conflict in this situation rests with the American public.

Walter E. Landgraf, writing for the September-October issue of the *Harvard Business Review,* put it a bit stiffer. Executive Director of the Allegheny General Hospital in Pittsburgh, Landgraf says:

"Public attention has mainly been focused on voluntary nonprofit hospitals . . . But the problem of rising costs and financial health services is not the sole property of the voluntary hospital; it is also the problem of society."

At the present time, everyone wants unlimited medical care — the best, the newest, the most. It has become a "human right" with almost constitutional status. But the fast-rising costs are creating a squeeze on other needs.

I'm sure we all realize — or should — that when costs are controlled, quality may be jeopardized.

Health care may have become an American right, but where such rights are guaranteed, whether by government or anybody else, the guarantee almost always assures only the minimum.

Cutting costs is not difficult.

As Harper Hospital Board Chairman Ray Eppert said in the January issue of *Hospitals* magazine:

"We could cut costs tomorrow just by arbitrarily reducing the quality of the product — that which goes on with the patient while he is in the hospital. We could also reduce our teaching and research. Instead of moving forward, we could stagnate. But our goal . . ."

In my opinion, the really intelligent approach is to agree not just on how to control costs, BUT ALSO on how to do it in a sound manner that will assure the highest quality of care possible.

Not easy!

Really worthwhile endeavors rarely are.

THAT'S WHY I HAVE but three observations, the most important one having to do with the public — which must make the important decisions.

All segments of the health care industry must work continually and at a much greater rate of speed to produce effective cost controls, while at the same time holding firmly to the highest possible quality standards.

This proposal, which encompasses the many, many suggestions in the voluminous studies made of every single part of the health care industry by public and private organizations, is the responsibility of health care experts.

It will call for far more cooperation and agreement than we've had in the past. The system is riddled with very serious conflicts . . . from the seemingly-praiseworthy desire of an individual, organization or community to establish a hospital where none is neded . . . to the unnecessary bickering that goes on between nurses' organizations about the shortage of nurses . . . to the suspicion with which profit-making nursing homes regard those who hold that profit should not be a prime motivation in the treatment of sick people . . . to the condemnation by too many physicians of everything but the traditional solo practice.

The list of expensive conflicts is long.

We must make continuing and greater efforts to resolve them.

The public must become more aware of its true interest — which is to obtain a workable balance between quality health care and a cost that is bearable.

Too long now, the problem has been in the hands of health care professionals, who cannot always shed their bias and who operate in an area where true competition has virtually ceased to exist.

We should stop expecting the rabbits to take care of the cabbage patch.

Health care professionals must be more willing, through free discussion and informational programs, to help the public understand the basic issues.

And the public must be listened to.

The current public attitude reflected in literature and in public and private studies is largely hostile criticism.

THE HOSTILITY HAS great potential. Because it expresses interest, it may bring public knowledge and understanding. This, in turn, may bring support for the cost-control mechanisms created by the health care industry, help resolve conflicts and answer questions those in the health industry cannot.

Much has been said of the value of an informed public. The American public's world-wide reputation for self-expression and determination is rapidly bringing itself to bear on health care costs.

We should apply our efforts through state and local planning to create a voluntary health care system to replace our present uncoordinated, basically inefficient conglomeration of good, fair and poor health care facilities.

The planning that has been done to date in many urban centers points the way. With much greater emphasis on the education of the public and of our state and local officials, there is no reason why we cannot keep voluntaryism in the saddle.

The people want good medicine, efficient institutions and reasonable prices.

ALL THINGS CONSIDERED, there is no reason why they cannot get these things from our voluntary health care system — to at least the same degree that industry provides its material blessings.

It is our collective job to make sure they do.

Blue Cross is ready, able and willing to help.

If the health care industry performs, as in my first suggestion, and if the public understands, as in the second, and if truly public groups can establish sound patterns with reasonable economic limits, then we can hope to avoid repeating our own errors — and those of others.

ACTIVITIES, PROJECTS

UNETHICAL TO USE PRESCRIPTION BLANKS WITH Rx IMPRINT

The ethic of physicians using prescription blanks with the name of a pharmacy printed thereon has been considered by the MSMS Judicial Commission. Donald N. Sweeny, Jr., M.D., Chairman, MSMS Judicial Commission, reports the Commission gave this matter careful study.

Under the authority invested in the Commission in Chapter 11 Section 8 (b) (Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.) of the MSMS Bylaws, have reaffirmed the 1964 opinion of the Judicial Council of the American Medical Association as follows:

> **It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon**

To insure that there be no misunderstanding on this matter by pharmacists, the Michigan State Pharmaceutical Association has been informed of the action and requested to make it known to pharmacists throughout the state. ☐

CANCER FOUNDATION ADDS MAN

Frank Jakes, Ph.D., formerly of Ford Motor, has been appointed by the Michigan Cancer Foundation, as executive vice president for community affairs. He will be responsible for development and coordination of educational, promotional and community service programs as well as other executive type assignments.

Doctor Jakes has been with Ford for 10 years as a training specialist in the industrial relations department, and with WSU. ☐

WIVES RATE PLAUDITS

Wives of two Michigan doctors have achieved notable "firsts." Mrs. William Fishbeck, Traverse City, elected to a four-year term on the City Commission of Traverse City, will be the Commission's first woman member. Mrs. Thomas J. Mudge, Marquette, has been appointed to the eight-member Michigan Mental Health Advisory Council, the Council's first member from the Upper Peninsula. ☐

SEES KIDNEY MACHINES IN HOMES WITH DOCTORS GIVING FOLLOW-UP CARE

Joseph W. Eschbach, Jr., M.D., University of Washington, told the Seventh Annual Michigan Kidney Foundation Disease Symposium May 24 and 25 in Grand Rapids that patients with kidney failure must be cared for at home with the patient's local physician providing "astute follow-up care."

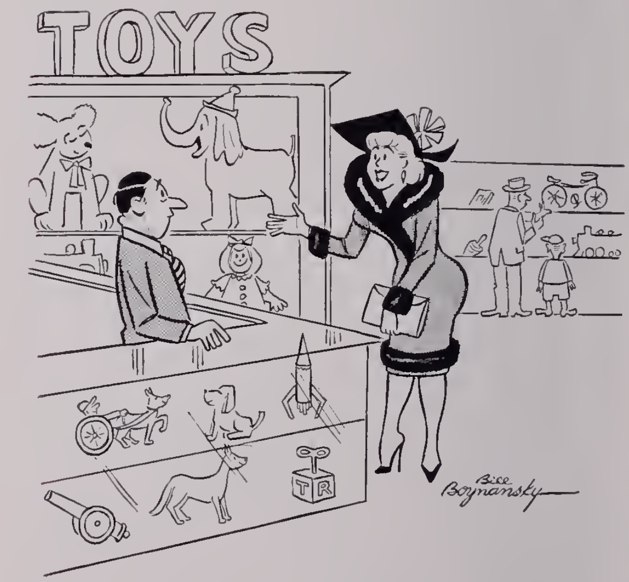
The follow-up, he said, will include office calls every one to four months and monthly blood tests.

The experience at the University of Washington Center, he said, has been that most local physicians are happy to take over care of patients after they are released. Many physicians have visited the center for instruction. He recommended eight to ten hours of dialysis three times weekly. ☐

A Social Imperative

"Sweeping societal change now dictates a reappraisal of this earlier philosophy which placed nearly its total investment in the education of the child. The impact of automation, the accelerated obsolescence of knowledge, increasing longevity, and the shrinkage of the world are all factors which now render the continuing education of the adult a social imperative."

— Edwin L. Novak, President
Michigan State Board of Education



"Where can I buy some of these mental blocks you hear so much about?"

Utilization Review Systems; Characteristics and Operation

ABSTRACT: The concept of a utilization review system is developed along the lines of a closed, (continuous) self-corrective process which brings together the basic components of medical care in a manner which allows qualitative and quantitative statements to be made about medical care. The basic components of the utilization review system are then described and contrasted with examples from operational systems.

BY CARL JOSEPHSON, DIRECTOR
UTILIZATION REVIEW RESEARCH PROJECT
MICHIGAN BLUE SHIELD

In two previous articles in this series, a number of forces in our society were shown to exert pressure on the medical care system to achieve the "best medical care for the most people at the lowest cost."

One method of both encouraging and measuring the progress toward this goal is through an effective utilization review system. The system, however, to be effective must be closed and self-corrective. That is, the review process must encompass all of the components of medical care — it must describe the medical goals of the community in quantifiable terms; it must evaluate the patient care that is being rendered, third-party payers, and socio-medical factors in the patient-doctor relationship. The system should be self-corrective in the sense that information gained from the review process is fed back into the medical system in a constructive manner. Utilization review committee reports, journal publications of changing patterns of medical care, and revised course curriculums are some of the continuing educational by-products of the utilization review system.

THE TRADITIONAL HOSPITAL-based utilization review system is organized around a review committee of staff physicians who look at preselected cases with the intent of evaluating the patient care and, where indicated, informing the attending physician of its findings. When the internal structure of the utilization review committee is analyzed and the many possible variations which can occur are enumerated, as illustrated in Chart I, the complexity of the problem is readily apparent.[1]

The purpose of the task is to maximize the effectiveness of the utilization review committee by the optimum allocation of available medical personnel to solve each hospital's particular utilization problems. As with the structure of the utilization committees, the actual review process contains a number of significant variations within the basic components. Some of these variations are shown in Chart II.

The time when a case is selected for review (i.e. type of review) is an important factor to consider in establishing a utilization review system since it influences the choice of other component variations. For example, the choice of concurrent review may be taken at the time of admission or at some stage during the inpatient stay. While this method can be used to effect the patient's continuing care (i.e. concentrate on "deviant" cases while they are in the hospital), it cannot evaluate the total medical care. Another type of review is the retrospective study which reviews the medical records of discharged patients. Retrospective re-

This is the third in the series of articles dealing with Utilization Review prepared by the staff of Michigan Blue Shield.

The author, Carl Josephson, is the director of the Utilization Review Research Project. He has had several years of experience in working on research projects for Blue Cross and Blue Shield plans ranging from the two national organizations in Chicago, Blue Cross Association and National Association of Blue Shield Plans to local plans in Michigan, Indiana and California.

—Louis F. Hayes, M.D.
Vice President, Medical Affairs
Michigan Blue Shield

view studies may sample all types of patient categories and review many components of patient care simultaneously. The manner of selection of cases for review ranges from complex models based on probability sampling of selected characteristics from the patient population, such as payment status, diagnostic category, and length of stay, to the review of an entire discharged patient population.

Retrospective studies employing computer techniques can secure data about patterns of patient care while performing the selection of cases. Many of the larger hospitals and hospital-based service bureaus are developing computerized screens to assist in the selection and initial evaluation of patients' records. Whenever the computer is employed to assist in the selection of cases or the evaluation of patient care, it is necessary to develop normative patterns of patient care and/or predetermined medical criteria as an index or baseline comparison. This is in contrast to the reviewer who relies on his own professional judgment on an *ad hoc* basis.

WITH SO MANY POSSIBLE variations in the components of a utilization review system, it is understandable that many different operational systems have evolved. The Monroe County study

Chart I
Utilization Review Committee Structure*

COMMITTEE COMPOSITION AND ORGANIZATION	VARIATIONS
Size	Numeric and variable
Membership	Physicians; administration; medical record librarian; social service; nursing; community members; health officers; etc.
Selection of Members and Officers	Elected or appointed by Medical Staff, Executive Committee, Utilization Committee, or Administration because of staff membership, position on medical staff, interest, or specialty
Term of Office	Rotation; non-rotating; some permanent members
Assignment of Cases	Full committee compliment, sub-committee units, or individual physician's review of all cases, cases by type of service, cases at random, or cases at specified time intervals
Frequency of Meetings, and Individual Review	At specified time intervals: daily, weekly, monthly, etc.; as needed
Responsibility of Members	Review of cases; formulation of policy of committee; formulation of standards for individual review
Relationship to Other Committees	Overlapping membership; informal discussions; subcommittee of other staff committee; no relationship

* Adapted from Greaney, Morisse, and Wilson, "A Study of Utilization Review Mechanisms Employed in Connecticut Hospitals," May, 1967; unpublished masters thesis, Yale University School of Medicine.

Chart II
Essential Components to the Utilization Review Process*

COMPONENTS	VARIATIONS
Type of Review	At time of admission; concurrent; retrospective
Case Selection	Total patient population; diagnostic categories; deviant cases; either all or on a sampling basis
Components of Patient Care Reviewed	Necessity of admission; length of stay; delays in diagnostic and therapeutic procedures; delays in consultation; quality of care received
Data Sources	Insurance records; medical record (full record, abstract, face sheet, check list); physician interview; patient observations
Method of Evaluation	Ad hoc peer judgment (individual or group basis); predetermined medical criteria

* Ibid

and the Nassau County pilot study, for example, were developed to test two systems of utilization review. While both systems used retrospective review by individual reviewers, the former relied on *ad hoc* professional judgment and the latter on informal, but flexible, predetermined criteria. Variations between different reviewers as well as variations between the same reviewers at different time intervals were found to be less pronounced where the use of predetermined criteria was followed.

Under the New Jersey A.I.D. system (Approval by Individual Diagnosis), a concurrent review system using certification techniques was developed with the assistance of three outside agencies — New Jersey Medical Service, New Jersey Hospital Association, and the Blue Cross-Blue Shield Plans. Each patient upon admission is given an estimated length-of-stay according to the admission diagnosis. Should the patient's stay extend beyond this estimate, a form indicating the necessity for continuing care must be completed by the patient's physician. Copies of this certification form are attached to the patient's chart and sent to the hospital utilization review committee.

IN CONTRAST TO individual case review methods, the HUP (Hospital Utilization Project) has developed a patterns review technique whereby electronic data processing methods are used to obtain data from all hospital discharges. Specific diagnostic groups are analyzed so that inter- and intra-hospital comparisons can be made on patterns of patient care. HUP is sponsored by the local medical societies and Blue Cross Plan of western Pennsylvania. Each hospital completes an abstract form from the medical record of all discharge cases. These abstracts are coded and compiled into a case listing for use by the hospital as a screening device. HUP in addition prepares a series of comparative statistics and special reports which highlight significant variations in patterns of care that would justify the attention of a hospital utilization review committee.

As with all of the systems described so far, individual case review is still performed within the hospital; however, the emphasis is placed on reviewing patterns of normal care rather than deviant use. HUP provides technical consultation to assist the local hospitals in their interpretation and use of their reports.

The Professional Activities Study (PAS) began in 1950 as an experiment in centralized collecting and processing of data on hospital medical care. It began with a few hospitals in Michigan and expanded to include hospitals throughout the United States, Puerto Rico, Canada, and New Zealand. PAS is similar to the HUP system in that it uses case abstracts for data collection and prepares case listings and monthly comparative statistical reports and summaries. The case abstracts, however, are more detailed as are the statistical reports. When interpreted correctly, the reports can be used for retrospective review of admissions, duration of stay, evaluation of professional services furnished, and the appropriate use of hospital facilities and services.

THE EXISTING UTILIZATION review systems are developed mostly for use by hospital staffs. As such, they tend to concentrate on individual case review techniques and are seldom used for evaluating the patterns of medical care being rendered in the community. The growth of third-party prepayment systems financing a significant proportion of the health care dollar and insuring large population groups have precipatated evaluative studies of the efficiency and effectiveness of the organization and delivery of medical care. The accumulation and centralized processing of records by these health carriers have provided another dimension to the review system. Redefinitions of the units of measurement and changes in the emphasis from specific deviant cases to measurement of normative patterns of care will provide the necessary base-line statistics that can lead to comprehensive problem definitions and corrective programs. ☐

Staudacher Leaves Post As SAMA Executive

Russell F. Staudacher, MSMS staff member from 1949-51, retired June 30 after 18 years of service as the executive director of the Student American Medical Association. Mr. Staudacher, who suffered a heart attack last December, is serving as consultant to several associations.

Charles Hewitt, former attorney and administrative assistant for the American Academy of General Practice, will succeed Mr. Studacher. ☐

DIRECTORY AVAILABLE OF SERVICES TO AGING

The Michigan Commission on Aging has issued a new "Directory of Services" which may be of interest to some physicians. A copy is available from the Commission, 1101 S. Washington, Lansing 48913.

The Directory provides general information about programs and assistance available to older people, how to apply for such benefits as the Homestead Tax Exemption, and opportunities in employment, recreation and education. ☐

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Report on Michigan Regional Medical Program

BY DON MARSHALL, M.D., KALAMAZOO
REPRESENTATIVE OF MSMS TO MARMP
VICE PRES., BOARD OF DIRECTORS, MARMP

The Officers, Council and Delegates of the MSMS, as well as the general membership, should keep informed of the progress of the Heart, Cancer, Stroke Program in this state. They should consider and decide a number of questions regarding the program. They should aid in a study of medical needs in Michigan that might properly and advantageously be met by this program.

Considering first the program from the national aspect, there is little doubt that the RMP is here to stay for the foreseeable future. Congress is pleased with it so far, it is doing good, much initial skepticism is disappearing, and it is now firmly started in all states. The program is being administered as originally outlined, with initiative and approval for the start of each project resting locally in the region, rather than in Washington. The program also is stimulating and demanding cooperation at the local level in a manner never before achieved. These are the two outstanding features of the law and its implementation: a) Washington approves nothing not first approved by the local region, and b) Washington approves no regional plan or activity that cannot first demonstrate that all concerned local groups are participating and agree on it.

UP TO THIS TIME the RMP (PL89-239) and the Comprehensive Planning Act (PL89-749) are cooperating closely, but the latter is not preparing to swallow the former. They are not alike, though they overlap in spots.

The factor in RMP that is beginning to blur is the limitation to heart disease, cancer, stroke and related diseases. These are medically so all-encompassing that to survey or study or educate for these categorical diseases alone simultaneously prepares often for similar action for all medical ailments. There early was urging that the categorical limitations be removed, and it seems likely that the first major change in the law will be in that direction.

The basic purposes of the RMP will bear repeating: 1) To reduce the time lag between the discovery and effective application of new knowledge, in the field of medicine; 2) To improve the quality and effectiveness of medical care; 3) To bring together the diverse groups in the health care field, for more effective results and to improve patient care.

Already 1,000 medical institutions are in various ways participating in the RMP. This includes every medical school and hundreds of hospitals. Eight hundred health organizations are participating, including every State Medical Society, every state health department, every state heart association and cancer society. The RMP in the U.S. employs over 1,800 salaried employees, full or part time, and over 7,000 non-Federal-connected individuals are active in it. The first planning grant was made two years ago; now about 24 regions have received or are in process of getting operational grants.

THE STEPS COVERED in setting up a regional program could be outlined as follows: 1) involvement and commitment of the individuals and institutions concerned; 2) the identification of needs and opportunities; 3) an assessment of resources, both physical, personnel, and ability; 4) determination of objectives; 5) setting priorities; 6) implementation; 7) evaluation of results.

The AMA supports the RMP so long as it continues to be administered as it has been, to catalyze and to facilitate better programs to serve patients and their physicians. In 5 of the 54 regions a State medical society is the program grantee, or heads the regional program. These are Georgia, D.C., Nebraska, Minnesota and Pennsylvania. The AMA testified before Congress in March that "We feel that the program has been administered very well, and with restraint and good judgment."

Since November 1967 the Michigan Association for Regional Medical Programs has had a central executive office in East Lansing headed by Albert

AUTHOR

DOCTOR MARSHALL

E. Heustis, M.D. The Board of Directors meets monthly and the Regional Advisory Group every three months. There are several professional advisory groups and task forces. In the coming year it is expected that a few field men will be hired to facilitate communication in the various areas of the state. The program everywhere has started around medical schools, but from Congress on down there is a clear desire and effort promptly to involve the profession and hospitals in smaller and rural communities.

TO DATE THE MICHIGAN State Medical Society has been involved in MARMP as follows: 1) It has an official representative on The Board of Directors; 2) Many of the committees of the Society are watching the program (Cancer, Cardiac Disease Control, Postgraduate Education, Rehabilitation, Aging, Diabetes, Rural Medical Service, Education Liaison, Cancer Coordinating); 3) To inform the society of MARMP activities a) a meeting of the chairmen of the committees listed above was held in October 1967; b) two programs on MARMP were given at the Annual Meeting in September 1967; and c) a variety of articles and announcements have been published throughout the year in *Michigan Medicine*; 4) Most of the scores of individuals active in MARMP today are MD's, and nearly all members of MSMS.

Despite all this integration of MSMS into the MARM Program, the point deserves reconsideration on whether the present participation of MSMS is all that it should be, and in the most efficient form. Much of the skepticism with which the medical profession met this national program at its start has disappeared, and has been replaced with support and even enthusiasm. The program is now a fairly husky baby of two years, with quite a potential for good that MSMS should be well aware of. It would seem logical that specific activities of MSMS in the Michigan RMP should be initiated and monitored by our various committees. In addition, county medical societies and the medical staff of all hospitals should become informed of the program and the potential for participation and help. Lastly any group or individual with suggestions or requests should feel free to communicate directly with either MSMS or with Dr. Heustis at the MARMP office, 1111 Michigan Avenue, East Lansing. ☐

MAEDC ISSUES HANDBOOK RE EMOTIONALLY DISTURBED

The Michigan Association for Emotionally Disturbed Children (MAEDC) has recently published a handbook which lists all Michigan services which are currently available for the care of emotionally disturbed children.

"Professional and lay members of MAEDC repeatedly have pointed out that there are directories on residential care for children, hospital services, and directories on educational programs, but nowhere is there one comprehensive listing of all services for disturbed children in Michigan," says Samuel L. Davis, Executive Director of the Association.

To fill the gap, the Association has published "Finding Programs for Troubled Children." It will be of special interest not only to pediatricians and general practitioners, but all physicians who are called upon to make reference for the care of children.

To receive a copy free of charge write: MAEDC, 668 Pallister Avenue, Detroit 48202.

Members of MAEDC are professionals and interested citizens dedicated to promoting the welfare of emotionally disturbed children. MSMS members on the MAEDC board of directors are William D. Harrelson, M.D., of Kalamazoo, Edward H. Rodda, M.D., of Bay City, and G. Fred. Moench, M.D., M.P.H., of Midland. ☐

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan — MU 5-8441

Edwin M. Williamson, M.D.
M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME

The Network
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Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including:

Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to
NCME, 342 Madison Avenue
New York, N.Y. 10017

Four Cities Receive Model City Grants

Under a new Model Cities Program, planning grants have already been awarded to four Michigan communities: Detroit; Genesee-Flint; Highland Park; and Saginaw.

Public Law 89-754, the Model Cities Program, is intended to revitalize the physical and social environment in blighted areas in cities and demonstrate that social and physical problems in these areas can be solved by concentrated and coördinated application of federal, state and local public and private resources in representative urban areas.

With federal assistance up to 80% of the local contribution, this program can be used to rebuild and revitalize large slum and blighted areas, expand housing, expand jobs and income opportunities, reduce dependents on welfare, improve educational facilities and programs, *combat disease and ill health,* reduce crime and delinquency, enhance recreational and cultural opportunities, establish better access between homes and jobs and in general, improve living conditions.

Michigan physicians will have a prime interest because health components in this program will be concerned with physical and mental health services and facilities excessible to and used by all residents of the area, including health education, personal services, diagnostic and therapeutic services, rehabilitative and restorative services, and areawide environmental health services.

This new program, as well as other federal programs, will attempt to utilize all available resources to attack serious social, economic and health problems and will seek coordination and assistance from MARMP (Michigan Association for Regional Medical Programs).

Other major provisions include the liberalization of FHA and mortgage insurance for group practice facilities, urban renewal, rural housing, land development in the new communities and urban information and technical assistance services.

Michigan Statistics About Health Care

The Health Insurance Institute recently released the following data on health care in Michigan:

Extent of Health Insurance Coverage for Persons Under Age 65 and Other Figures

Number of persons with hospital expense insurance	7,242,000*
Number of persons with surgical expense insurance	6,725,000*
Number of persons with regular medical expense insurance	5,967,000*
Number of persons with major medical expense insurance**	2,146,000
Total health insurance benefits paid (1965)	$608,910,000
By insurance companies for hospital, surgical and medical care, including loss of income	$273,625,000
By Blue Cross, Blue Shield, Medical Society-approved and or-sponsored and independent plans for hospital, medical and surgical care	$335,285,000
Number of health insuring organizations licensed in the state (338 insurance companies, 2 Blue Cross, Blue Shield and Medical Society plans, and 7 independent plans)	347

Hospital Statistics (1966)***

Number of hospitals in state	200
Number of hospital beds available	30,966
Number of persons admitted during the year	1,115,897
Number of persons under hospital confinement on an average day	25,424
Number of full-time hospital personnel per 100 patients	265
Average length of time a patient remained in hospital	8.3 days
Average cost per hospital stay	$436.25
Professional Services	
Number of physicians in private practice (December 31, 1966)	6,603
Number of non-federal dentists (Mid-1966)	4,455
Number of registered, practicing resident pharmacists (Jan. 1, 1967)****	5,175
Number of employed professional registered nurses (1962)	21,465

---

*Net total of people protected—eliminates duplication among persons under age 65 protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage.

**Persons under 65 years of age with insurance company coverage.

***Non-federal, short-term general and other hospitals.

****In practice in state.

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You Help Support "Michigan Medicine"

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60
Lederle
PERITINIC
Hematinic with Vitamins and Fecal Softener
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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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Pearl River, New York 10965

488-7R—6062

painful night leg cramps...
respond to specific therapy with
QUINAMM™
(Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

The Bettman Archive

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Top 12 Health Insurance Plans* in the USA

(Based on 1966 data from the *Argus Chart* published by the National Underwriter Company, and reprinted from the Michigan Blue Shield - Blue Cross Highlights publication)

	EARNED FEE INCOME	% PAID OUT IN BENEFITS	% USED FOR OPERATING EXPENSES**
1. Metropolitan Life	$718 million	84.3%	14%
2. Aetna Life	626½ million	88.7%	11%
3. Travelers	574 million	88.2%	11.4%
4. Prudential	503 million	77.8%	19.1%
5. New York City Blue Cross & Blue Shield	439 million	95.0%	7.1%
6. Michigan Blue Cross & Blue Shield	374 million	94.0%	4.7%
7. Equitable Society	363½ million	86.3%	11.5%
8. Continental Casualty	357½ million	70.0%	27.0%
9. Mutual of Omaha	356½ million	73.9%	26.8%
10. Connecticut General	241 million	88.1%	13.8%
11. Massachusetts Blue Cross & Blue Shield	223 million	95.1%	4.5%
12. New Jersey Blue Cross & Blue Shield	202 million	93.5%	5.0%

*Blue Cross is a name for 75 autonomous Plans sponsored by hospitals throughout the nation; total Blue Cross membership income for 1966 was $3 billion-plus. Likewise, Blue Shield is the generic name for 73 autonomous Plans sponsored by medical societies throughout the nation; total Blue Shield membership fee income for 1966 was $1.4 billion. Together, then, for 1966 Blue Cross and Blue Shield nationally had $4.14 billion income; this was greater than the premium income of the top 10 commercial companies combined.

The two other members of the "top 10 commercials" are John Hancock Mutual, $186 million income, and Bankers Life & Casualty, $164 million.

**Operating expenses, when added to benefits paid out, will not necessarily come to 100%. On their total health insurance business during 1966, most of the "top 12" were in a gain position. This, despite the fact that eight of the "top 10 commercials" registered losses on group business, one as much as $8 million. Where overall losses were sustained, losses were made up in one of three ways:

(1) adjustment of the fee charged;

(2) investment income, or

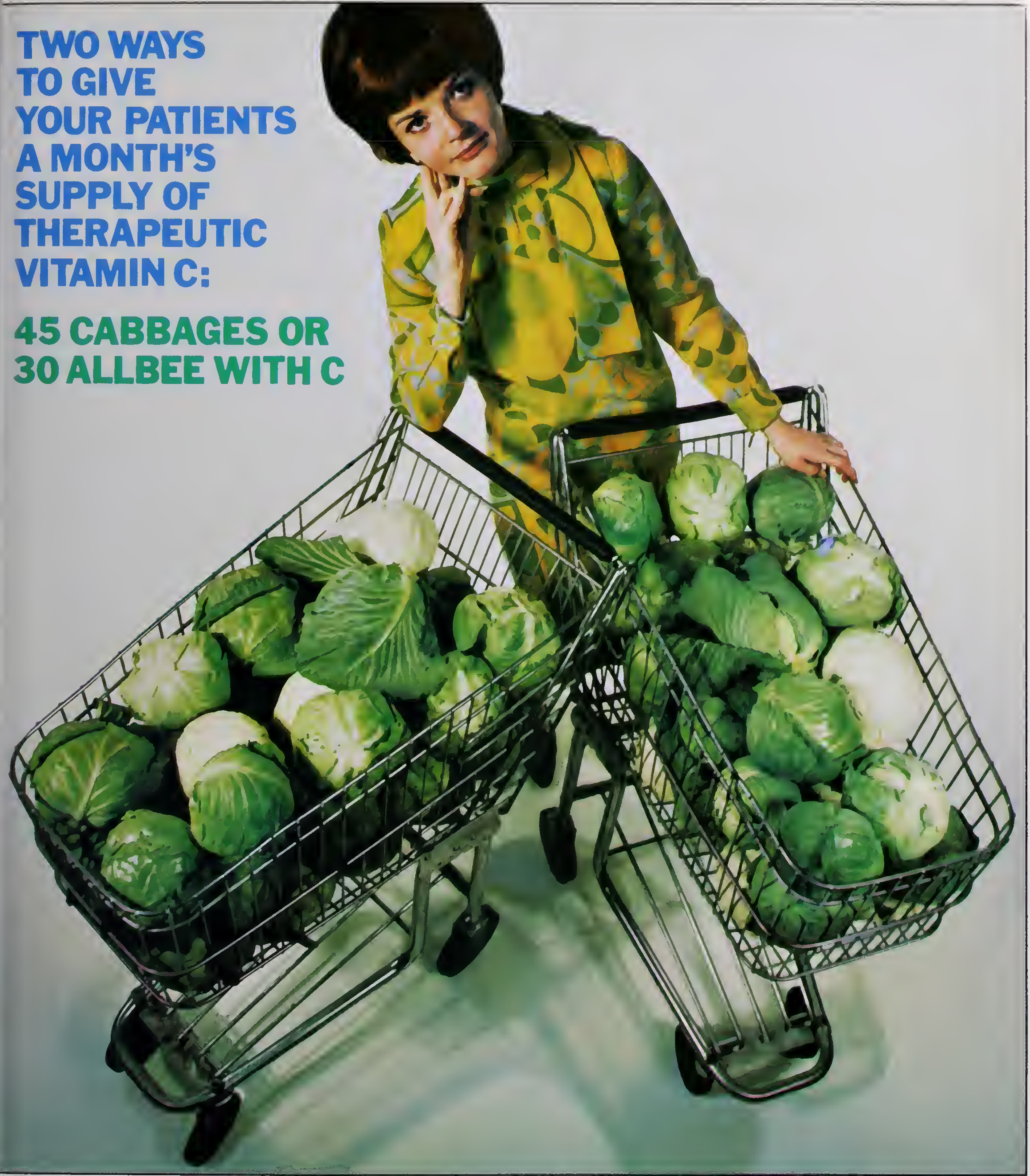
(3) subsidy by some other part of the fringe-benefit program. ☐

> ***"Medical education is a continuum. Continuing education should be an integral part of the physician's life — from the time he enters secondary school until the close of his career."***
>
> — **The Coggeshall Report**

MSMS ANNUAL SESSION, SEPT. 25-26

SHERATON-CADILLAC, DETROIT

House of Delegates, September 22-23-24


TWO WAYS
TO GIVE
YOUR PATIENTS
A MONTH'S
SUPPLY OF
THERAPEUTIC
VITAMIN C:
45 CABBAGES OR
30 ALLBEE WITH C

our patient would have to eat 45 cabbages a month
-1/2 a day) to get as much vitamin C as is contained in
st one bottle of 30 Allbee with C capsules (taken one
apsule daily). In addition, each capsule provides full
erapeutic amounts of the B-complex vitamins. For
xample, as much niacin as 2 pounds of sirloin steak.

rite "30" for B and C deficiencies. This handy bottle of
) Allbee with C capsules gives your patient a month's
upply at a very reasonable cost. Also the economy size
f 100. Available at pharmacies on your prescription or
ecommendation.

. H. Robins Company, Richmond, Va. 23220.

30 Capsules
Allbee® with C
Each capsule Contains:
Thiamine mononitrate (Vit. B1) 15 mg
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Pyridoxine hydrochloride (Vit. B6) 5 mg
Niacinamide 50 mg
Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg
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DONNATAL
2 tablets
3 times daily

the spasm
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in your practice
deserve

"the Donnatal® Effect"

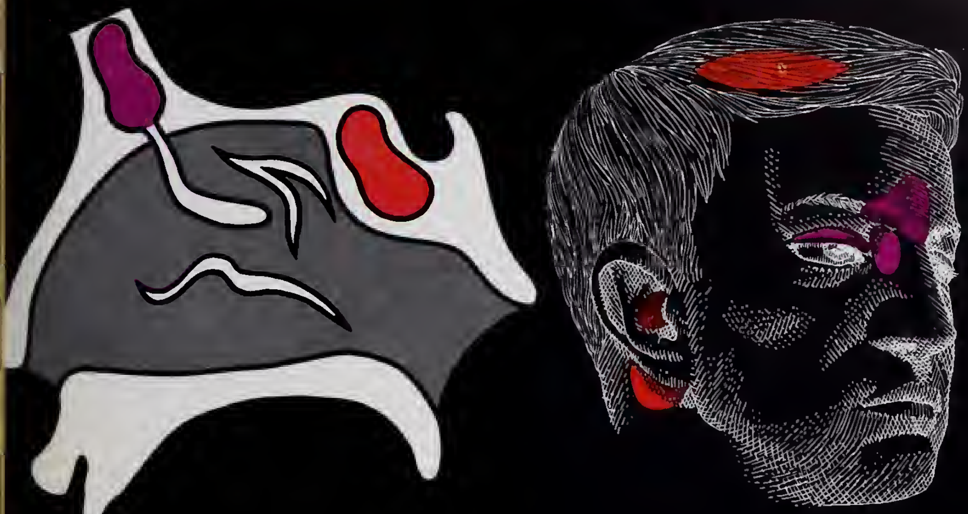
	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

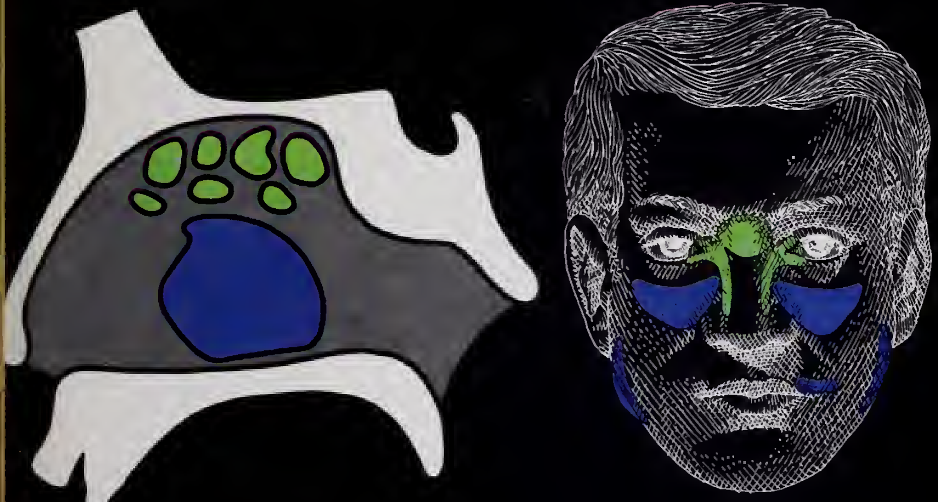
A·H·ROBINS

Sources of sinus headache

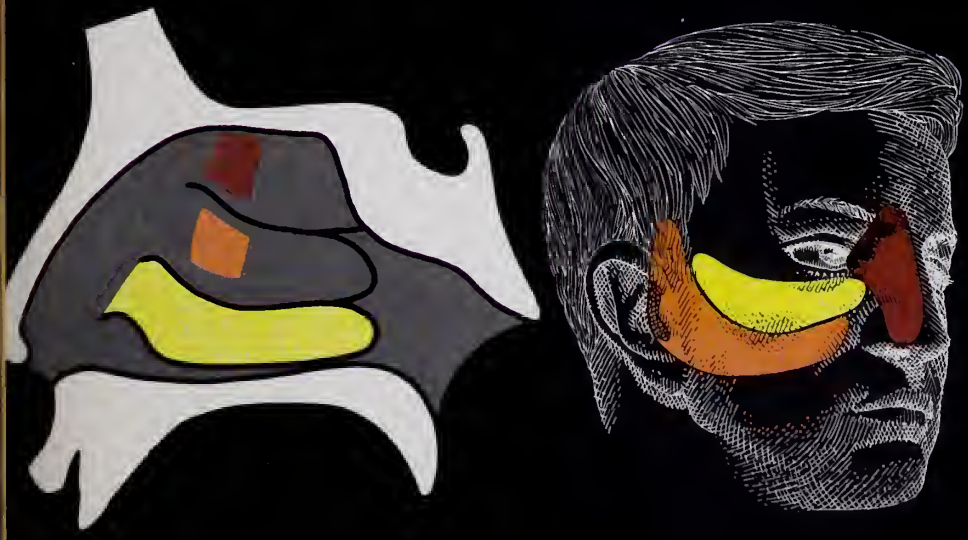


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA
SINUTAB®
FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

W|C **WARNER-CHILCOTT** Morris Plains, N.J.

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millions of doses prescribed

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(diphenhydramine hydrochloride)

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PARKE-DAVIS

When it's more than a bad cold

your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8

WYCILLIN
MEPERIDINE 75 mg
THIAMINE 100
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SPARINE 100
MEPERIDINE 100 mg
TETANUS ANTITOXIN
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Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
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- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
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Just select, inject, throw away

TUBEX®

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sterile cartridge-needle unit
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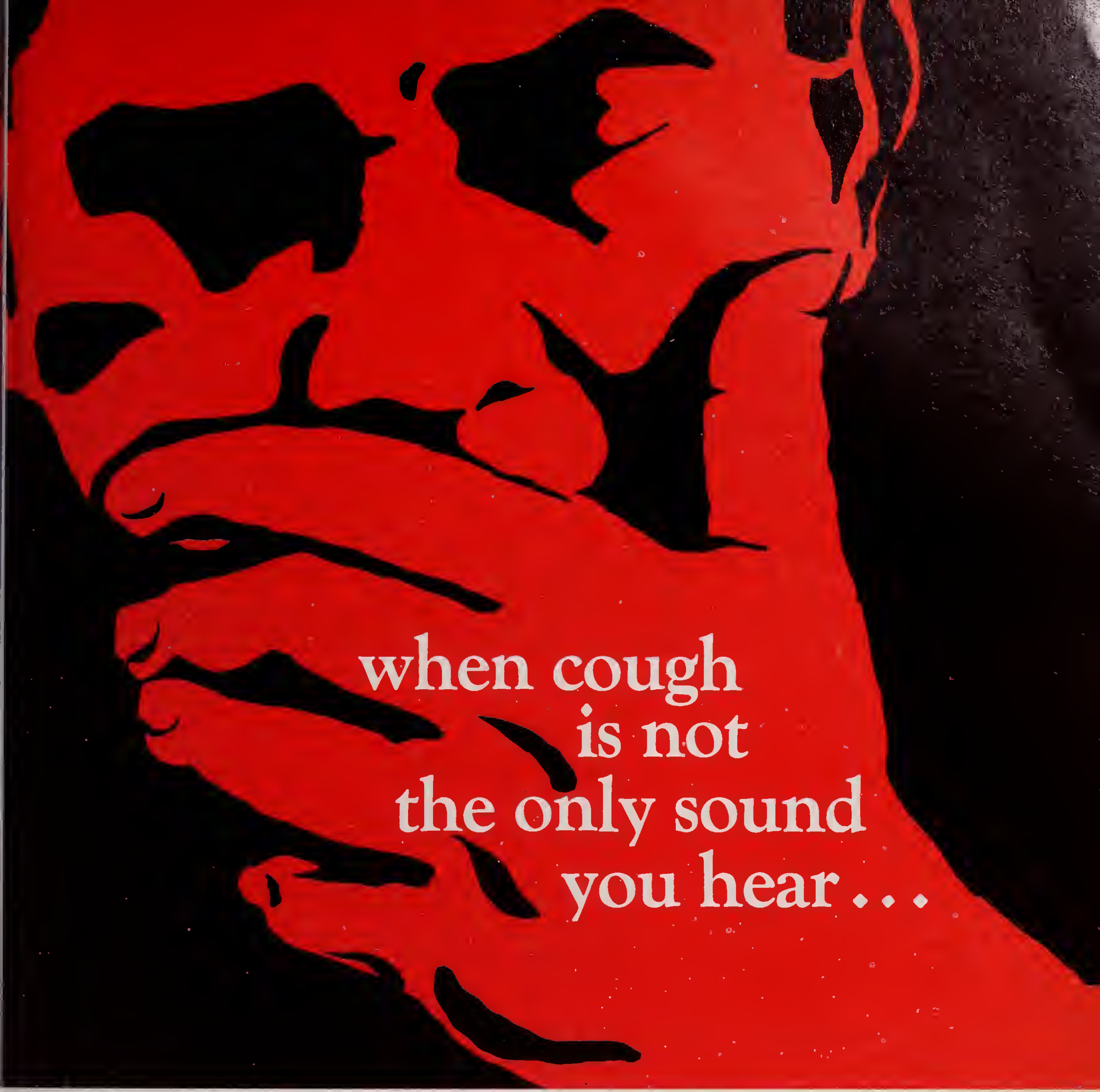

OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

new evidence for TAO® (triacetyl-oleandomycin)

No tooth staining reported after 10 years of use.

a macrolide antibiotic for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital.

*Staphylococcus aureus

study I[1] Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0% of the organisms were susceptible to oleandomycin*

98.0% of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2] Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that **TAO® (triacetyloleandomycin)** was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. *following is a brief precautionary statement.*
Contraindications: Severe central nervous systen depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients whc have previously exhibited a hypersensitivity reac (e.g., blood dyscrasias, jaundice) to phenothiazine Phenothiazines are capable of potentiating centra nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports leukopenia and/or agranulocytosis and convulsiv seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentar retinopathy may be avoided by remaining within recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving Orthostatic hypotension is more common in fema than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System—* Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism an other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System—*Dryness of mouth, blurred visi constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System—* Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin—*Dermatitis and skin eruptions of the urtica type, photosensitivity. *Cardiovascular System—* Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any signific disturbance of cardiac rhythm, several sudden an unexpected deaths apparently due to cardiac arre have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other—*A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxie and mixed anxiety-depressio

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With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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These Firms Make '68 Annual Session Possible without a Registration Fee

One of the colorful and educational aspects of the MSMS Annual Session in Detroit this September will be the interesting array of exhibits.

MSMS leaders say, "Take time to inspect each one — not just a casual look — but a real indepth study. You will be surprised at the wealth of new information they will offer you."

Following is a list of the firms who will be presenting displays at the 1968 MSMS Annual Session. Doctors are urged to make a special effort to visit each booth to personally express appreciation and to ask questions.

Income from the leasing of exhibit space makes it possible for MSMS to present its excellent Annual Scientific Session without a registration fee.

The intermission periods between scientific sessions will provide excellent opportunities to study the exhibition. The registration desk, meeting rooms, and exhibits will be conveniently located on the same floor as the meetings.

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

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For profound calming effect in moderate to severe mental and emotional disturbances of everyday practice.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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New State Laws, Now In Effect, Explained

(Editor's Note: This first article in a series describes the Senate bills which passed the 1968 legislature and were given immediate effect. Next month, an article will discuss the House-introduced new laws which went into effect upon being signed by the governor.

During the 1968 session, the Michigan State Legislature enacted 26 new important health laws, 11 of them originating in the Senate and the remaining 15 having been initially presented in the House.

In the case of each new law, however, unless the Legislature orders that the law shall become effective upon signature by the Governor, the law does not become operative until 90 days after the Legislature finally adjourns. Since it is now anticipated that the 1968 adjournment will come in late August, many new health laws will not have effect until the latter part of November, 1968.

This first article will discuss the salient features of those Senate bills which passed the entire Legislature, were given immediate effect and have been signed by the Governor. Any Senate bills not covered in this article may be assumed to lack effect for several more months (such as the new hospital licensing law, for example) and will be explained in a subsequent article published near the date the law becomes operative.

CHIROPRACTORS, under new Public Act 73 of 1968, now practice under the following definition: chiropractic is considered to be "the locating of misaligned or displaced vertebrae of the human spine, the procedure preparatory to and the adjustment by hand of such misaligned or displaced vertebrae and surrounding bones and tissues, for the restoration and maintenance of health."

The law now goes on to provide: A licensed doctor of chiropractic under this act may use X-ray and such analytical instruments as are approved by the Michigan board of chiropractic examiners in the examination of patients solely for the purpose of locating misaligned or displaced vertebrae of the human spine and for the procedures preparatory thereto.

It should also be noted that the law now provides that the Chiropractic board *may* suspend or revoke a chiropractor's license for: "being guilty of false, fraudulent or misleading advertising or advertising in which grossly improbable statements are made; or advertising in any publication or media free services or consultation, or the prices for which his services are available; or for having professional connection with any firm of corporation who advertises contrary to these provisions."

Persons noting a chiropractor advertising in such a manner as is prohibited above should, the law says, write to the Chiropractic board secretary (200 Lafayette Building, in Detroit), in triplicate. The board *may* call a hearing and can discipline the offender if it finds him guilty. It should be noted that this law has always given this board authority to discipline for "fraudulent," "grossly improbable," or "misleading" statements. The new element is the prohibition against advertising "FREE" services, or stating fees for services.

COUNTIES WITH LESS THAN 75,000 population which have not previously availed themselves of the provisions of the Community Mental Health Services Act, Act 54 of 1963, may now join in an existing program in an adjacent county, if the adjacent county's board of supervisors approves and if the State Department of Mental Health grants necessary approvals also. The new law making this possible is Public Act 205 of 1968.

IMPORTANT FLUORIDATION legislation was passed by the adoption of Public Act 346 of 1968, which makes two important provisions. First, it specifically prohibits any instrumentality of state government from ordering the fluoridation of water supplies. Second, it provides as a legislative action that *all* public water supplies must be fluoridated before July 19, 1973 *unless* the addition of fluoride has been rejected by an ordinance of the local governing body or by a majority of the electors voting on the question.

Townships and counties may now either operate, OR CONTRACT FOR, ambulance and inhalator services under the provisions of Public Act 163 of 1968. The law became effective on June 17 and provides "good samaritan" protection for ambulance drivers, attendants, policemen and firemen (except for acts or omissions constituting gross negligence or willful and wanton misconduct, as well as requiring the passage of a Red Cross first aid course by such persons before they are entitled to the protection of the law.

Here is a quote from the new statute: "The township board of any township and the board of supervisors of any county may operate or join with another municipality or contract with persons, firms, organizations or corporations in operating or furnishing an ambulance and inhalator service for the use and benefit of the residents of the township or county. The service by the town-

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ship or the county may be in connection with fire protection service or as a separate operation."

The Michigan law governing the Department of Social Services in its administration of the categorical aid programs (old age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled) has been amended by Public Law 232 of 1968 to permit third parties, acting in behalf of applicants, more latitude to function on the applicant's behalf. This new law, a purely technical administrative change, takes cognizance of the growing utilization of third parties.

Also in regard to the categorical assistance programs, the Legislature in passing Public Act 169 of 1968 has clearly stated that while other records, applications, etc. shall be open to inspection "All records relating to persons applying for, receiving or formerly receiving medical services under the categorical assistance programs . . . . shall be confidential and shall be used only for purposes directly and specifically related to the administration of the medical program."

THE FOREGOING SIX new health laws are presently in effect. Other important health legislation, which will not become effective until late November of 1968 and which will be reviewed in a future article, includes hospital licensing, added funds for alcoholism programs, sex education, waiver of basic science requirement due to passage of national boards, and making it a felony (rather than a misdemeanor) to practice medicine without a license.

The next article in this series will cover House-introduced new laws passed in 1968 which went into effect upon being signed by the Governor.

Hemophilia Clinic Slated Soon in Grand Rapids

An Evaluation and Diagnostic Clinic, sponsored by the Michigan Chapter, National Hemophilia Foundation, will be held Saturday, September 28, at Butterworth Hospital, Grand Rapids.

Physicians having hemophilic patients who would benefit from this clinic may contact the office of John Penner, M.D., Hemophilia Control, Room S 6360, University Medical Center, Ann Arbor, and an application and referral form will be sent.

Participating in the clinic will be Doctor Penner, G. Anderson, M.D., Grand Rapids; Genevieve Howen, M.D., Grand Rapids; Claude Raby DDS, Grand Rapids. ☐

U-M Hospital Predicts Need for $110 Million In Expansion by 1978

A long-range planning report prepared for the University of Michigan Hospital anticipates a construction program totaling about $110 million within the next decade "to meet the immediate health care needs" of the institution through the year 2000.

BLUE CROSS COMPUTERS SERVING LOCAL HOSPITALS

Michigan Blue Cross has added a new dimension in computer service for Michigan hospitals.

The Hospital Computer Services, a new division, offers to Blue Cross participating hospitals a complete range of computer services supported by a staff of professional consulting and systems people.

Wm. S. McNary, Blue Cross president, said, "This new program links Michigan hospitals to a central computer for the purpose of performing a number of administrative services — quickly, efficiently and at lower cost than any individual hospital could hope to achieve."

In this respect, Michigan Blue Cross is the first Plan in the country to have a pilot project that is working with clinical people and trying to adapt computer technology to clinical requirements. This is a job of magnitude and complexity with different objectives from that of the business office.

In carrying out this role, Blue Cross is uniquely capable because of its technological capability, experience, and economic strength already dedicated to minimizing hospital costs and improving patient care.

Recent studies have indicated that the need for information processing assistance to hospitals has become more acute as governmental, medical, administrative and population demands on hospitals have increased and become more complex. These demands necessitate increased expansion in clinical and administrative processing and reporting requirements. The federal government is already interested in the management techniques and economics of hospitals as well as the level or scope of patient care through its regional medical programs — programs like Medicare, Medicaid, and hospital and medical insurance for Federal Employees.

Cottage Hospital in Grosse Pointe Farms, was the first Michigan institution to elect to share the Blue Cross Hospital Computer Service. Art Center Hospital will join in September and Sinai Hospital in November. ☐

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING AUGUST 2, 1968

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	20	33	253	897
Whooping Cough	37	108	284	645
Diphtheria	0	0	0	0
Mumps	194	611	13,010	12,784
Scarlet Fever & Strep Sore Throat	445	530	7,041	9,472
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	196	125	1,256	1,175
Salmonellosis (Other than S. typhi)	46	56	399	312
Typhoid Fever (S. typhi)	0	2	0	6
Shigellosis	37	22	154	281
Aseptic Meningitis	11	12	37	31
Encephalitis	4	14	52	81
Meningococcic Meningitis	4	10	63	50
Influenzal Meningitis	5	11	36	34
Tuberculosis	263	298	1,682	1,772
Syphilis	523	414	3,298	3,407
Gonorrhea	2,061	1,715	10,342	9,941

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."

—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

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MERCY

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

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A simplified approach to the practical management of hypertension

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

METHYCLOTHIAZIDE
No. 6812
ENDURON®
METHYCLO-
THIAZIDE
5 mg

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient' sodium excretion is greatly enhanced. Yet potassium loss is low

The therapeutic action is smooth, and persists for a full 24 hours With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectiveness

Of course, as with all thiazides, supplemental dietary potassiur should also be considered.

Use Enduron as a basic therapy in patients with mild to moc erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day

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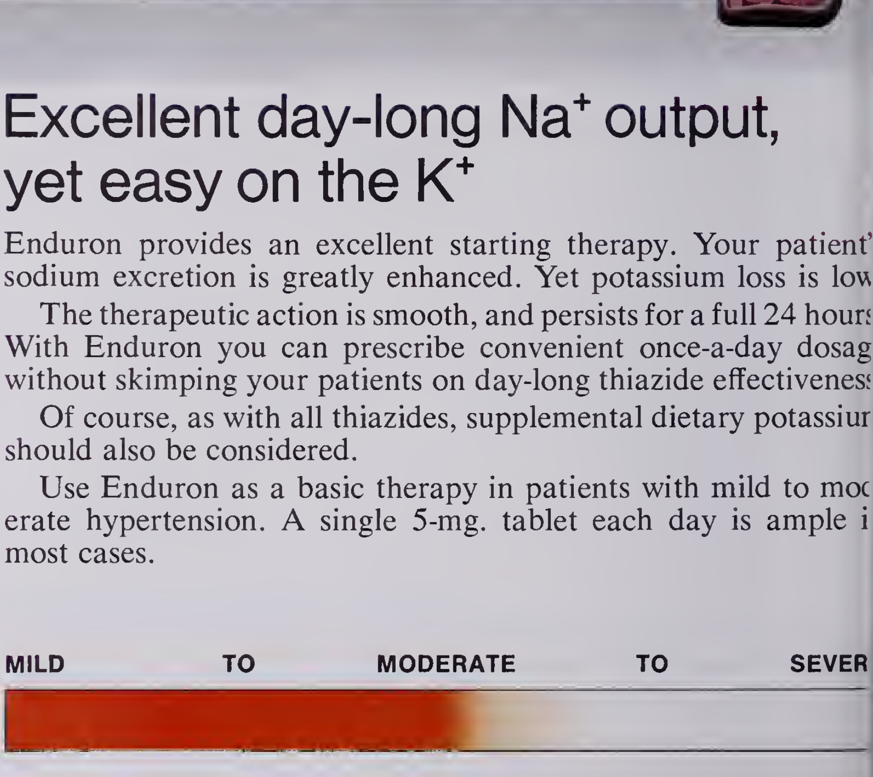
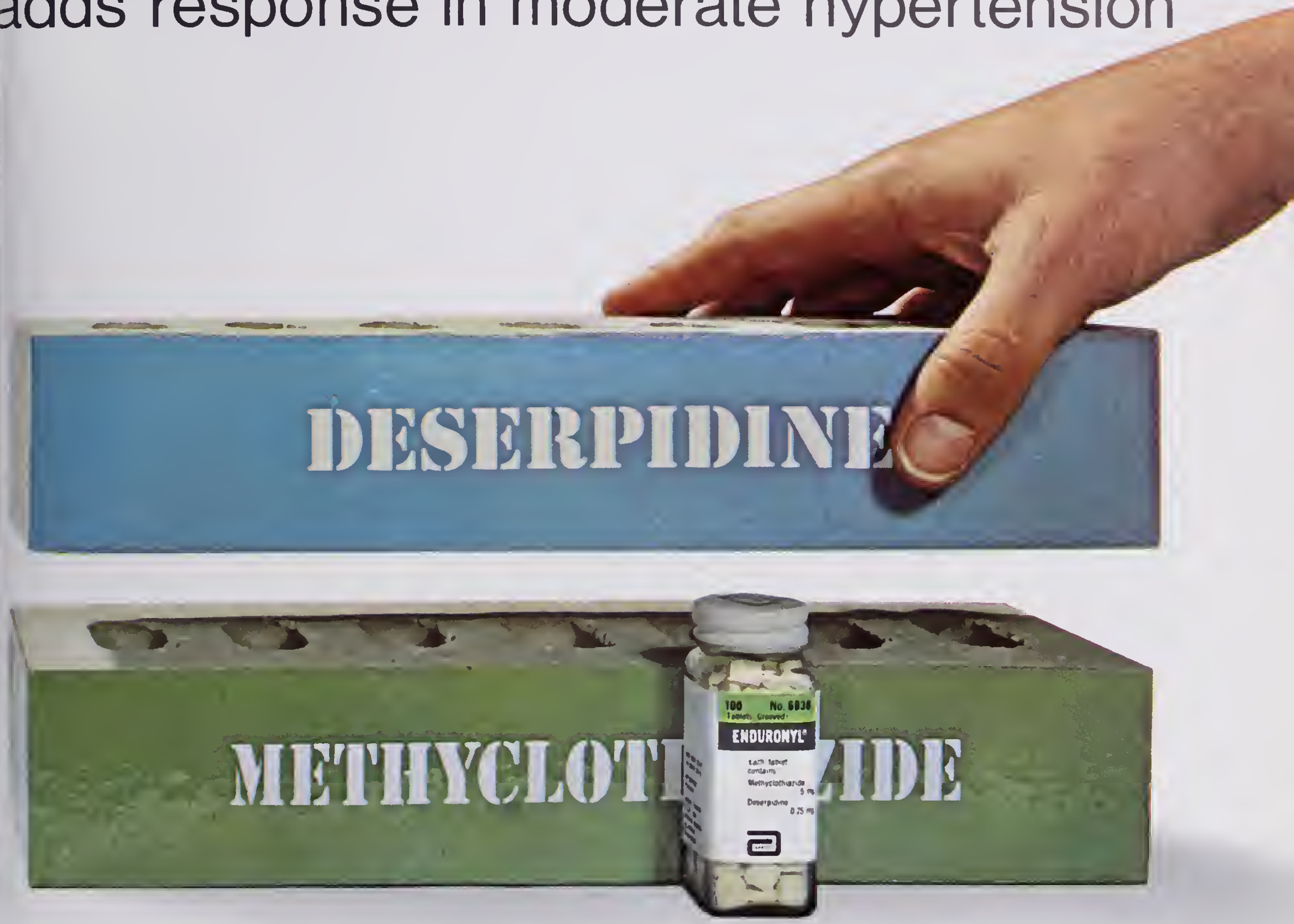
METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

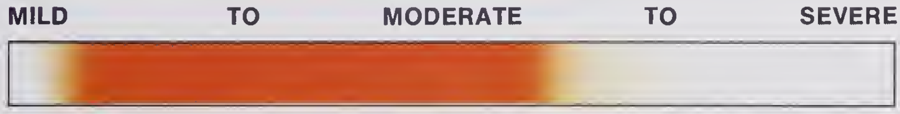
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



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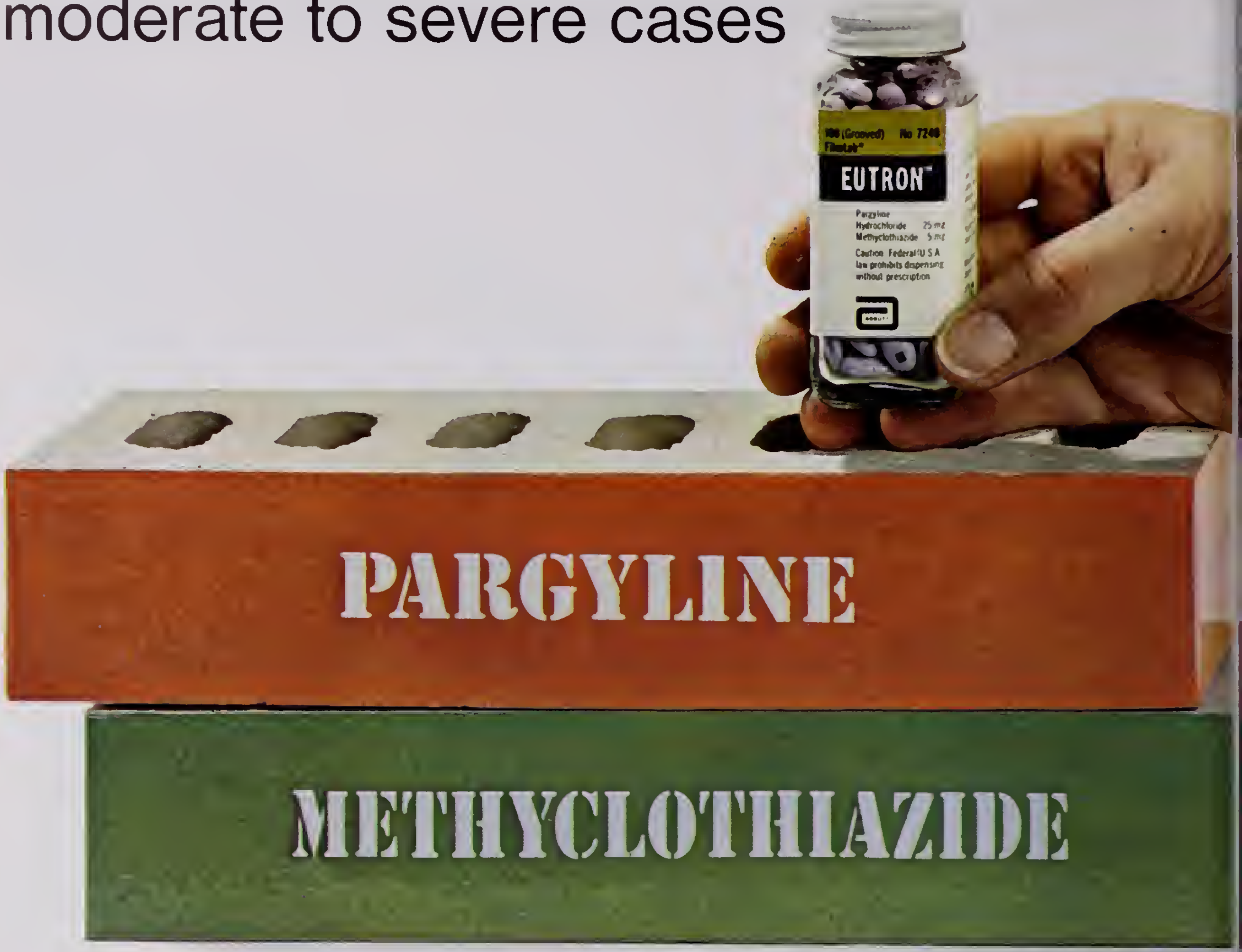
801094

Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.) law prohibits dispensing without prescription
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METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether you patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings wer reduced from 112 pre-treatment to 90 post-treatment; *sitting* fro 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearl alike in all three body positions.

Use Eutron for managing your moderate to severe cases. It building blocks enhance each other; hence lesser doses often suffice

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVER

See Brief Summary on final page of advertisement

80109

ENDURON®

METHYCLOTHIAZIDE

ENDURONYL®

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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IN MEMORIAM

Lawrence Berman, M.D., Detroit

Lawrence Berman, M.D., professor at the Wayne State University School of Medicine, died July 8. He was 59.

Doctor Berman's teaching appointments at Wayne State University were Professor of Hematopathology, Associate in Anatomy, and Associate in Medicine. He was affiliated with Veterans, Oakwood, Beaumont, St. Joseph's, Mercy, Sinai, and Receiving hospitals in Detroit, and St. Joseph's Hospital, Pontiac.

He received the M.D. degree from the University of Minnesota in 1937. He interned at Minneapolis General Hospital, Minneapolis, Minnesota, 1936-37, and did a residency at the University of Minnesota Hospital from 1938-41. He did postgraduate studies in pathology and hematology and received the M.S. degree in 1941.

Doctor Berman was a member of the International Hematology Society, American Board of Pathology, American Society of Pathologists and Bacteriologists, American Society of Clinical Pathologists, College of American Pathologists, Phi Beta Kappa, Sigma Xi and Alpha Omega Alpha. He published extensively in scientific journals.

P. F. Coleman, M.D., Livonia

Peter F. Coleman, M.D., Livonia specialist in obstetrics and gynecology, died July 8 at the age of 64.

Doctor Coleman received his premedical education at City College of New York, New York City, and his M.D. degree from Rush Medical College, Chicago, Illinois, in 1930. Internship was done at the Cook County Hospital and Chicago Lying-In Hospital, 1930-31. His residency was at New York Polyclinic Hospital, 1943-45. He did postgraduate work at Basic Science University of Pennsylvania Medical School.

He was affiliated with St. Joseph Hospital and Grace Hospital, Detroit, and Plymouth General Hospital.

Doctor Coleman was a member of the American Society of Abdominal Surgeons and the American Board of Obstetrics and Gynecology. He was also a member of Kiwanis of Livonia and Phi Delta Upsilon medical fraternity.

A. J. Telego, M.D., Grand Rapids

Anthony J. Telego, M.D., pathologist at Blodgett Memorial Hospital, Grand Rapids, died July 18. He was 50.

Doctor Telego was graduated in 1949 from the Marquette University School of Medicine in Wisconsin. His internship was done from 1949-50 at E. W. Sparrow Hospital in Lansing, where he was a resident in pathology from 1950-51.

After three years in general practice in Youngstown, Ohio, Doctor Telego served in the U.S. Army Medical Corps, 1954-56, as Chief of Laboratory Service of the U.S. Army Hospital, Ft. Leonard Wood, Missouri. In 1956-57, he did a residency in pathology at Sibley Hospital and Hunter Laboratory, Washington, D.C. He joined the staff at Blodgett Hospital in 1958.

He was a member of the American Society of Clinical Pathologists, Association of Clinical Scientists, Association of Clinical Pathologists, Michigan Society of Pathologists, and Phi Chi fraternity.

A. E. Thomas, M.D., Detroit

Alfred E. Thomas, M.D., Detroit physician and civic leader, died July 1 at the age of 59.

Doctor Thomas received his M.D. degree in 1937 from Meharry Medical College and later served as a member of the Meharry Board of Trustees. He was awarded an honorary doctorate from Ferris Institute where he did his premedical studies.

During World War II, he served in the U.S. Army Medical Corps, earning the rank of Lieutenant Colonel. He was a flight surgeon for the 99th Pursuit Squadron stationed at Tuskeegee Army Airfield in Alabama, and he later served in Liberia, West Africa.

Long active in the NAACP in Detroit and nationally, Doctor Thomas was a member of the first Human Relations Committee of the Detroit Police Department. He was a contributor to the African Art Gallery of the Detroit Institute of Arts and established an annual scholarship at the University of Windsor. He founded and managed two hospitals in Detroit.

OFFER BIBLIOGRAPHY ON EMERGENCY SERVICES

A list of folders and booklets has been compiled by the Michigan State Medical Society which deal with emergency medical care and emergency ambulance service.

These publications, which will be of great assistance to staff persons, are available for the asking. The list can be obtained by writing PR Committee, MSMS, P.O. Box 152, East Lansing, Mich.

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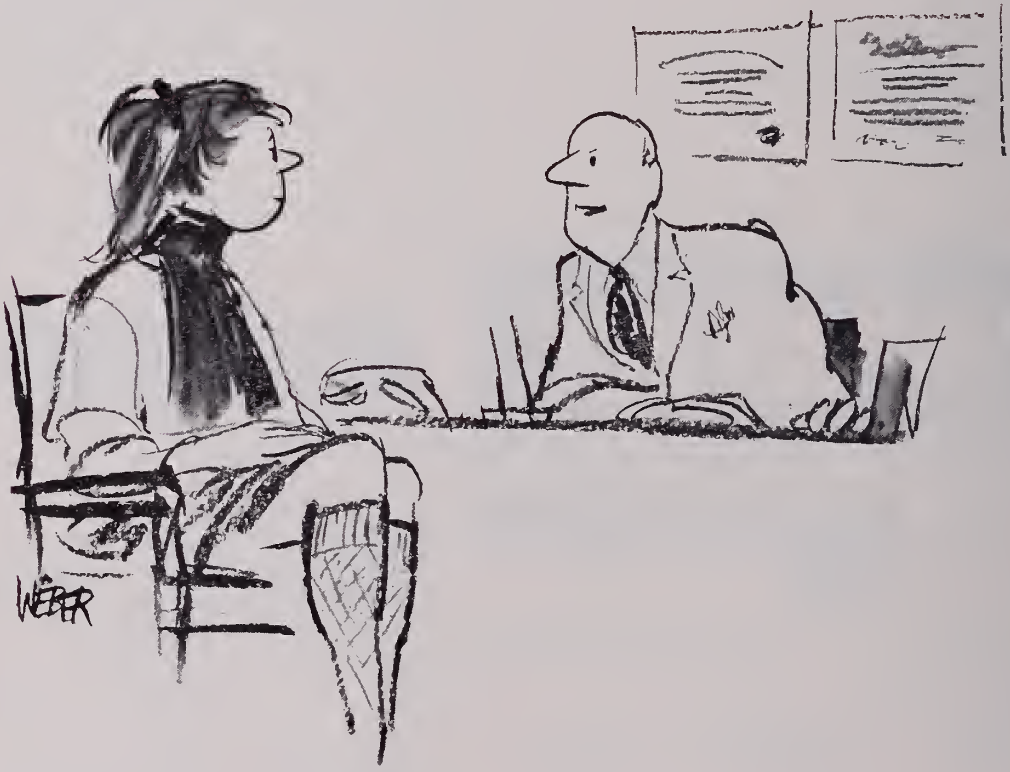

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H. Ross Hume, M.D. ....Detroit
Chairman
George D. Stilwill, M.D., Sec. ....Lansing

Pathology

Murray R. Abell, M.D. ....Ann Arbor
Chairman
Edwin M. Knights, M.D., Sec. ......Southfield

Pediatrics

Anthony C. Gholz, M.D. ....Port Huron
Chairman
John L. Doyle, M.D., Sec. ....Grand Rapids

Physical Medicine

Edwin M. Smith, M.D. ....Ann Arbor
Chairman
George H. Koepke, M.D., Sec. ....Ann Arbor

Plastic Surgery

Alexander P. Kelly, M.D. ....Detroit
Chairman
Joseph H. Naud, M.D., Sec. ....Detroit

Proctology

John R. Heaton, M.D. ....Grand Rapids
Chairman
George Kinsley, M.D., Sec. ....Pontiac

Psychiatry & Neurology

Glenn G. Golloway, M.D. ....Ann Arbor
Chairman
Henry Krystal, M.D., Sec. ....Detroit

Public Health & Preventive Medicine

Gordon A. Eadie, M.D. ....Newberry
Chairman
Maurice S. Reizen, M.D., Sec. ....Lansing

Radiology

Robert S. Ormond, M.D. ....Dearborn
Chairman
Robert A. Songe, M.D., Sec. ....Dearborn

Surgery

Robert O. Northway, M.D. ....Saginaw
Chairman
Joseph A. Witter, M.D., Sec. ....Highland Park

Thoracic Surgery

Cameron Haight, M.D. ....Ann Arbor
Chairman
Raymond J. Barrett, M.D., Sec. ....Detroit

Urology

Edward J. Shumaker, M.D. ....Detroit
Chairman
James M. Pierce, Jr., M.D., Sec. ....Detroit

VOLUME 67, NUMBER 18 • SEPTEMBER 1968 • DEADLINE FOR COPY, SEPT. 11, 1968

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

Program
1968 Annual Session

The Planning Committee assures you that the 1968 Annual Scientific Session provides multiple opportunities to obtain much useful, new information for your daily practice. The committee, with the cooperation of the Section Officers, has made progressive changes in the format by developing seminars, roundtable discussions, and clinical conferences and postgraduate courses.

A. J. Walt, MD
Chairman, Program Committee

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REGISTRATION

MICHIGAN STATE MEDICAL SOCIETY		
Fourth Floor	Tuesday, September 24	8:30 a.m. - 10:00 p.m.
Sheraton-Cadillac Hotel	Wednesday, September 25	7:15 a.m. - 5:30 p.m.
	Thursday, September 26	7:15 a.m. - 5:30 p.m.
WOMAN'S AUXILIARY		
Statler-Hilton Hotel	Tuesday, September 24	11:00 a.m. - 3:00 p.m.
	Wednesday, September 25	8:00 a.m. - 4:00 p.m.
	Thursday, September 26	8:00 a.m. - 12:00 noon
MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY		
Pontchartrain Hotel	Tuesday, September 24	7:00 a.m. - 9:00 a.m.
	Wednesday, September 25	7:30 a.m. - 12:00 noon
	Thursday, September 26	8:00 a.m. - 10:00 a.m.

Annual Session, September 25-26 Offers Depth and Variety of Subjects

SEE "AT A GLANCE SCHEDULE" ON PAGES 1144 AND 1145

"At A Glance Schedule"

WEDNESDAY, SEPTEMBER 25

		PAGE
ALL DAY	Postgraduate Courses:	
	Infectious Diseases	1168
	Pulmonary Diseases	1170
7:30 - 8:45	Continental Breakfast Round Table:	
	Use of Laparoscope	1149
	MDPAC Congressional Breakfast	1147
9:00 - 10:00	General Meetings in Ballroom A & B:	
	Breast Carcinoma	1150
	Selective Abdominal Arteriography	1151
10:00 - 10:45	Intermission to View Exhibits	
10:45 - 12:00	General Meetings in Ballroom A & B:	
	Breast Carcinoma (continued)	1152
	Problems of the Fetus	1153
12:00 - 2:00	General Luncheon	
	"Drugs, Doctors & Government"	1153
2:00 - 3:15	General Meetings in Ballroom A & B:	
	Trauma	1154
	Pediatric Problems	1155
3:15 - 4:00	Intermission to View Exhibits	
4:00 - 5:00	General Meetings in Ballroom A & B:	
	Trauma (continued)	1154
	Relief of Pain	1155
5:00 - 6:00	Fireside Discussions with the Speakers	
7:30	Presidents Party: Reception, Buffet, Dancing, Ala Carte Cocktails	1154
ALL DAY	Activities of MSMS Sections:	
	Allergy & Applied Immunology	1157
	Anesthesiology	1155
	Dermatology	1156
	General Practice	1157
	Obstetrics-Gynecology	1149
	Ophthalmology	1157
	Otolaryngology	1157
	Pediatrics	1155
	Physical Medicine	1157
	Plastic Surgery	1156
	Public Health & Preventive Medicine	1156
	Radiology	1147, 1157
	Surgery	1154
ALL DAY	Meetings of Related Groups:	
	Detroit Roentgen Ray Society	1147, 1157
	Mich. Br., Am. Academy of Pediatrics	1147, 1157
	Mich. Soc. of Anesthesiologists	1147, 1155
	Mich. St. Med. Assistants Society	1147
	MSMS Woman's Auxiliary	1147
	Vanderbilt Medical Alumni	1147
	Wayne State Univ. Medical Alumni	1147

MS Annual Scientific Session

THURSDAY, SEPTEMBER 26

		PAGE
ALL DAY	Postgraduate Courses:	
	Blood Diseases	1172
	Digestive Diseases	1173
7:30 - 8:45	Continental Breakfast Round Tables:	
	Malignancies Genito-Urinary Tract	1149
	Carcinoma of Colon & Rectum	1149
	Anesthesiology	1149
9:00 - 10:00	General Meetings in the Ballroom:	
	Prostate Carcinoma	1158
	Cardiovascular Diseases	1159
10:00 - 10:45	Intermission to View Exhibits	
10:45 - 12:00	General Meetings in Ballroom A & B:	
	Calcium — Too Much — Too Little	1160
	Cardiovascular Diseases	1161
12:00 - 2:00	General Luncheon	
	"Clinical Organ Transplantation"	1161
2:00 - 3:15	General Meetings in Ballroom A & B:	
	Diabetes	1162
	What's New in the Practice Of —	1163
3:00 - 5:30	Office Management Seminar	1148, 1164
3:15 - 4:00	Intermission to View Exhibits	
4:00 - 5:00	General Meetings in Ballroom A & B:	
	Problems of the Aging	1164
	What's New in the Practice Of — (continued)	1165
ALL DAY	Activities of MSMS Sections:	
	Anesthesiology	1149
	Internal Medicine	1159, 1161
	Neurological Surgeons	1167
	Occupational Medicine	1166
	Orthopedic Surgery	1167
	Pathology	1148, 1166
	Proctology	1149
	Psychiatry & Neurology	1167
	Thoracic Surgery	1166
	Urology	1149

ALL DAY	Meetings of Related Groups:	
	Detroit Branch, American Urological Society	1148
	Michigan Assoc. of Neurological Surgeons	1148, 1167
	Michigan Diabetes Association	1148, 1162
	Mich. Orthopaedic Society	1148, 1167
	Mich. Soc. of Anesthesiologists	1149
	Mich. Society of Pathologists	1148, 1166
	Mich. Soc. of Psy. and Neurology	1148, 1167
	Mich. State Med. Assistants Soc.	1147
	MSMS Woman's Auxiliary	1147

GENERAL INFORMATION

MSMS OFFICE — Ontario Room, Fifth Floor, Sheraton-Cadillac Hotel

Hours: 8:00 a.m. to 5:00 p.m. each day.

MSMS MESSAGE CENTER — Check Room on the Fourth Floor (313/961-8000, Ext. 2948 and 2949)

Special lines will be installed for local and long distance telephone calls for registrants and exhibitors at the MSMS meeting.

CHECK THE MESSAGE CENTER BOARD REGULARLY FOR POSTED MESSAGES.

ANNUAL SESSION PROGRAM COMMITTEE — Alexander J. Walt, MD, Chairman, Detroit; T. A. Baker, MD, West Branch; W. C. Baum, MD, Grand Rapids; K. H. Johnson, MD, Lansing; A. M. Lerner, MD, Detroit; F. P. Rhoades, MD, Detroit; H. A. Towsley, MD, Ann Arbor; F. B. Bicknell, MD, Detroit; G. L. Brinkman, MD, Detroit; T. N. Evans, MD, Detroit; W. S. Haubrich, MD, Detroit; R. F. Wilson, MD, Detroit, and Neal A. Vanselow, MD, Ann Arbor.

MSMS NEWS ROOM — Michigan and Windsor Rooms, Sheraton-Cadillac Hotel

Hours: 8:00 a.m. to 5:00 p.m., each day.

TICKETS for the daily general luncheons, and other functions of related groups and sections will be available at the registration desk.

NO REGISTRATION FEE required for members of MSMS and other state medical associations, the AMA or the Canadian Medical Association.

ADMISSION to all meetings in the Sheraton-Cadillac Hotel and to the exhibits will be by badge only. Please present MSMS, other state medical association, AMA, or CMA membership card to expedite registration. This will save your time.

Interns, residents, medical students, and nurses are welcome to attend the scientific meetings.

DAILY GENERAL LUNCHEON for all registrants and speakers on Wednesday and Thursday. Tickets may be purchased at the registration desk. The cash bar and the luncheon area is open noon - 2:00 p.m.

INTERMISSIONS TO VIEW THE EXHIBITS will be provided on Wednesday and Thursday in the morning from 10 to 10:45 and in the afternoon from 3:15 to 4.

PAPERS WILL BEGIN AND END ON TIME — Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the programmed schedule. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and attending accordingly.

AAGP CREDIT: Members of the Michigan Academy of General Practice will receive credit for each hour they attend the 1968 Annual Session. Application for approval should be made to James Dooley, MD, Chairman, Commission on Education, 3210 S. Dort Highway, Flint.

NEW INFORMATION IN THE EXHIBIT

MSMS is proud to present an outstanding technical exhibit at its 103rd Annual Session.

All physicians are urged to visit the educational displays, to take advantage of the new information available, and also to express appreciation for the exhibitors' contributions to the MSMS postgraduate program.

MEETINGS OF RELATED GROUPS

WOMAN'S AUXILIARY CONVENTION: Tuesday through Thursday, September 24-26, Statler-Hilton Hotel.

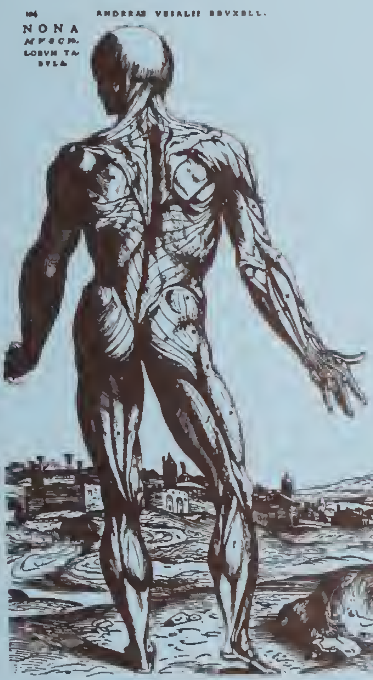
MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY CONVENTION: Tuesday through Thursday, September 24-26, Pontchartrain Hotel.

ALUMNI GROUPS:

The University of Michigan Medical Center Alumni Society will entertain in a hospitality suite Monday, September 23 from 4:30 to 6:00 p.m., Tuesday, September 24 from 11:30 a.m. to 12:30 p.m., and Wednesday, September 25 from 4:30 to 6:00 p.m.

The Wayne State University will entertain in a hospitality suite at the Sheraton-Cadillac Hotel on Tuesday and Wednesday, September 24 and 25, 1968. There will be a Reception in the Suite on Wednesday evening from 4:00 to 6:00 p.m. and Alumni, Faculty, and ex-Residents and Interns, with their spouses are cordially invited to attend. The Hospitality Suite will be open from 11:00 a.m. to 6:00 p.m. on both Tuesday and Wednesday and representatives of the Alumni Association and the School will be on hand to extend a most cordial welcome to visitors.

The Yanderbilt Alumni Association will hold a reception on Wednesday, September 25, from 6:30 p.m. to 8:00 p.m. in the West Room of the Sheraton-Cadillac Hotel. All members and their wives are invited.



All registrants at the MSMS Annual Session are cordially invited to visit the Detroit Institute of Arts to see the "Ars Medica" exhibit of more than 130 original prints about medicine. The above woodcut is attributed to the workshop of Titian (Italian, 1477-1576).

WEDNESDAY, SEPTEMBER 25

(See Page 1156 for Section Meetings)

MDPAC CONGRESSIONAL BREAKFAST: 7:30 a.m., breakfast meeting, Woodward Room, Sheraton-Cadillac Hotel. Tickets may be secured in advance by writing Michigan Doctors Political Action Committee, P.O. Box 169, East Lansing 4882[illegible] Cost is $4.00. The speakers will be Rep. John Conyers, Jr., (D), Detroit, and Rep. Donald W. Riegle, Jr., (R), Flint.

DETROIT ROENTGEN RAY SOCIETY and the MSMS SECTION ON RADIOLOGY: 6:00 p.m. reception, 7:00 p.m. dinner-meeting in the English Room (mezzanine floor). The speaker is Manuel Viamonte, Jr., MD, Miami, Florida, who will talk on "Lymphatic System."

MICHIGAN BRANCH, AMERICAN ACADEMY OF PEDIATRICS: 5:00 p.m. reception, 6:00 p.m. dinner-meeting at the Statler-Hilton Hotel. The Speaker is Leo Stern, MD, of Montreal, Canada, who will talk on "What's New with Hyperbilirubinemia."

MICHIGAN SOCIETY OF ANESTHESIOLOGISTS: Co-sponsors the general meeting on "Relief of Pain" from 4:00 p.m. to 5:00 p.m. and the Thursday Round Table Discussion on "Anesthesiology - 1975" from 7:30 a.m. to 8:45 a.m.

THURSDAY — NEXT PAGE

THURSDAY, SEPTEMBER 26

(See Page 1166 for Section Meetings)

MICHIGAN SOCIETY OF PSYCHIATRY AND NEUROLOGY: Meets with the Section on Psychiatry and Neurology for a reception and dinner-meeting beginning at 6:00 p.m. in the Woodward Room (fifth floor). The speaker is Professor John C. Burnham of Columbus, Ohio, who will talk on "American Medicine and the Development of an American Style in Psychiatry."

Spouses are invited to attend the reception and dinner.

MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS: Will meet with the Section on Neurological Surgeons for a reception and dinner-meeting beginning at 5:30 p.m. in Room 615 and the Boulevard Room (sixth floor). The speaker is Mr. Neal L. McCue, Detroit, who will talk on "The Neurosurgeon and Blue Shield."

DETROIT UROLOGICAL SOCIETY: Co-sponsors the Round Table Discussion on "Malignancies of the Genito-Urinary Tract" from 7:30 a.m. to 8:45 a.m. and the General Meeting on "Prostate Carcinoma" from 9:00 a.m. to 10:00 a.m.

MICHIGAN DIABETES ASSOCIATION: Co-sponsors the General Meeting on "Diabetes" from 2:00 p.m. to 3:15 p.m.

MICHIGAN ORTHOPAEDIC SOCIETY: Meets with the Section on Orthopedic Surgery beginning at 4:00 p.m. and followed by a reception and dinner in the Sheraton Room (fifth floor). The speaker is Ignacio V. Ponseti, MD, of Iowa City who will discuss "Studies of Trunk Growth in Normal Children and in Children with Growth Disorders."

MICHIGAN SOCIETY OF PATHOLOGISTS: Meets with the Section on Pathology from 9:30 a.m. to 5:00 p.m. A slide seminar on "Diseases of Skeletal Muscle" will be presented by William K. Engel, MD, Bethesda, Maryland, in the Woodward Room at 1:30 p.m.

The Business Meeting will be at 9:30 a.m. in the Washington Room; luncheon will be at 12:00 noon in the Woodward Room; a cash bar will be set up in the Book-Casino at 7:00 p.m.; and the Past Presidents Dinner is at 7:00 p.m. in the Book-Casino Room.

OFFICE MANAGEMENT SEMINAR FOR NEW PHYSICIANS, RESIDENTS, INTERNS, AND STUDENTS: Offered from 3:00 to 5:30 p.m.,Thursday, September 26 for newly-practicing physicians, residents, interns, and senior medical students.

Breakfast Roundtable Discussions
7:30 - 8:45 am
(Continental Breakfast served to all in attendance)

Wednesday

Sheraton Room
Fifth Floor

Use of the Laparoscope

Alfred I. Sherman, MD, Professor of Gynecology and Obstetrics, Wayne State University School of Medicine

Sponsored by Section on Obstetrics-Gynecology
Chairman: John P. Ottaway, MD, Grosse Pte. Farms
Secretary: Herman C. Eldersveld, MD, Grand Rapids

Business Meeting of Section on Obstetrics-Gynecology

Thursday

Washington Room
Fifth Floor

Malignancies of the Genito-Urinary Tract

George T. Mellinger, MD, Minneapolis, Chief of Urology Service, Veterans Administration Hospital; Chairman, Veterans Administration Cooperative Urological Research Group; and, Associate Professor of Urology, University of Minnesota

Willet F. Whitmore, Jr., MD, New York, Chief, Urologic Service, Memorial Hospital for Cancer and Allied Diseases; Clinical Professor of Surgery (Urology) Cornell Medical College

Sponsored by the Section on Urology and the Detroit Branch, American Urological Society.
Chairman: Edward J. Shumaker, MD, Detroit
Secretary: James M. Pierce, Jr., MD, Detroit

Business Meeting of Section on Urology

Sheraton Room
Fifth Floor

Treatment of Recurrent Carcinoma of the Colon and Rectum

Edward L. Moorhead, MD, Grand Rapids, Chief, Division of Medical Oncology, Butterworth Hospital

Sponsored by the Section on Proctology
Chairman: John R. Heaton, MD, Grand Rapids
Secretary: George Kinsley, MD, Pontiac

Business Meeting of Section on Proctology

Mason Room
Fifth Floor

Anesthesiology — 1975 — What Is It Or Through The Eye of The Needle

John W. Ditzler, MD, Chicago, Director, Department of Anesthesiology, Chicago Wesley Memorial Hospital; Professor of Anesthesiology, Northwestern University Medical School

Sponsored by the Section on Anesthesiology and the Michigan Society of Anesthesiologists, Inc.
Chairman: Shirley Austin, MD, Detroit
Secretary: Ralph E. Bauer, MD, Detroit

Wednesday Morning, September 25

Choose from Two Concurrent General Sessions

LECTURES ABOUT BREAST CARCINOMA

Ballroom B
(Fourth Floor)

9:00 - 10:00

BREAST CARCINOMA

Moderator: Alexander J. Walt, MD, Assistant Dean Wayne State University School of Medicine, Professor and Chairman, Department of Surgery, Wayne State University School of Medicine

The Problems and Aspects of Cure—Mammography and Xerography

John A. Wolfe, MD, Chairman, Department of Radiology Hutzel Hospital; Assistant Clinical Professor, Department of Radiology, Wayne State University School of Medicine

Xerograms of the breast have the following advantages over film mammograms:

1. They are easier to interpret
2. They require less radiation to produce than Eastman Kodak "M" film mammograms.
3. Xerograms afford greater detail.
4. The process is dry.
5. The finished product is obtained quickly and with great ease.

The most important feature is that they are easier to interpret. Properly set-up xerograms could probably be "read" in a screening program at the rate of 4-5 cases per minute whereas experience with film mammography in such a program revealed an ability of 15-20 cases per hour. An additional advantage of xerography is that all parts of the breast are clearly shown with one image.

The essential part of xerography is the "plate" which consists of a sheet of aluminum 10 x 17 inches coated with a thin layer of selenium and encased in a wooden "cassette" complete with a dark slide to protect it from light. The plate is used as one would an x-ray film.

A positive charge is placed on the selenium surface. X-rays make the selenium conductive perpendicularly. After exposure there is a residual charge pattern which may be made visible by "developing" with a negatively charged pigment containing powder.

Xerography is a simpler method of examination of the breast as compared to that done with conventional x-ray film. It is my belief more information can be obtained from a single xerogram than any single film mammogram. With a good technique xerography will afford a more accurate examination; but most important, it is more readily interpreted. The development awaits reliable equipment.

Indications and Results of Chemotherapy in the Management of Breast Cancer

Vainutis K. Vaitkevicius, MD, Associate Professor and Director of Oncology, Wayne State University School of Medicine

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10:00 - 10:45

Intermission to View the Exhibits

Ballroom A
(Fourth Floor)

9:00 - 10:00

SELECTIVE ABDOMINAL ARTERIOGRAPHY

Moderator: Roger L. Rian, MD, Associate Radiologist, Henry Ford Hospital

Angiography in Liver Diseases, Splenic Pathology, Pancreatic, Gastric, Small and Large Bowel and Renal Diseases

Manuel Viamonte, Jr., MD, Department of Radiology, School of Medicine, University of Miami

10:00 - 10:45

Intermission to View the Exhibits

Wednesday Morning, September 25

Choose from Two Concurrent General Sessions

MORE LECTURES ABOUT BREAST CARCINOMA

Ballroom B
(Fourth Floor)

10:45 - 12:00

(Continuation of Breast Carcinoma)

Aspects of Palliation
Surgical Aspects of Palliation

William J. Fry, MD, Professor and head, Section of General Surgery, University of Michigan Medical School

The Place of Radio Therapy in Carcinoma of the Breast

Doctor M. Betty Bennett, Capetown, South Africa, Senior Radio Therapist, Department of Radiotherapy, Groote Schuur Hospital, and Senior Lecturer, University of Capetown

Approach to Surgery of the Potentially Curable Case

Cushman D. Haagensen, MD, New York City, Department of Surgery, College of Physicians and Surgeons of Columbia University

William L. Donegan, MD, Surgeon, Ellis Fischel State Cancer Hospital and Assistant Professor of Surgery, University of Missouri School of Medicine

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All registrants are invited to General Luncheon

Ballroom A
(Fourth Floor)

10:45 - 12:00

PROBLEMS OF THE FETUS

Chairman: George E. LaCroix, MD, Associate Professor of Obstetrics and Gynecology, Wayne State University School of Medicine

Problems of the Fetus

Robert H. Usher, MD, Montreal, Quebec, Assistant Professor of Pediatrics and Obstetrics and Gynecology, McGill University

Pre and Postnatal Resusitation

John P. Harm, MD, Instructor in Pediatrics, Department of Pediatrics, Wayne State University School of Medicine

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12:00 - 2:00

Woodward Room
(Fifth Floor)

GENERAL LUNCHEON

Chairman: James J. Lightbody, MD, President-Elect Michigan State Medical Society

Report of 1968 of MSMS House of Delegates

Kenneth H. Johnson, MD, Lansing, Secretary

Drugs, Doctors and Government

Harry F. Dowling, MD, Chicago, Professor and Head, Department of Medicine, University of Illinois College of Medicine

Wednesday Afternoon, September 25

Choose from Two Concurrent General Sessions

LECTURES ABOUT TRAUMA

Ballroom B
Sponsored by the Section on Surgery.

Chairman:
Robert O. Northway, MD, Saginaw

Secretary: Joseph A. Witter, MD, Highland Park

2:00 - 3:15

TRAUMA

Moderator: Paul W. Gikas, MD, Ann Arbor, Chief Laboratory Service, Veterans Administration Hospital

The program will be devoted to a discussion of some of the problems associated with the immediate care and transportation of the acutely injured patient. The inadequacies of emergency medical services in general will be emphasized and the role of the physician in solving some of the problems will be stressed.

Needed Changes in Emergency Health Care

J. Cuthbert Owens, MD, Denver, Professor of Surgery, University of Colorado Medical Center

The Extrication of Injured Personnel from Wrecked Vehicles

Louis C. Kossuth, Colonel, USAF, MC, Command Surgeon, United States Air Force, Aerospace Defense Command, Colorado

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3:15 - 4:00

INTERMISSION TO VIEW THE EXHIBITS

Ballroom B
(Fourth Floor)

4:00 - 5:00

(CONTINUATION OF TRAUMA)

Panel on "The Management of a Patient with Multiple Injuries

Moderator: Robert F. Wilson, MD, Professor of General Surgery, Wayne State University School of Medicine

Paul W. Gikas, MD, Ann Arbor, Chief, Laboratory Service, Veterans Administration Hospital

Harvey Y. Lewis, MD, Associate Professor of Urology, Wayne State University School of Medicine

J. Cuthbert Owens, MD, Denver, Colorado, Professor of Surgery, University of Colorado Medical Center

L. Murray Thomas, MD, Clinical Professor and Assistant Chairman, Department of Neurosurgery, Wayne State University

Business Meeting of the Section on Surgery

Book Casino
(Lobby Floor)

5:00 - 6:00

Fireside Discussions with Speakers

Grand Ballroom
Fourth Floor

6:00 - 8:30

PRESIDENTS PARTY

Reception, Buffet, Two Bands for Dancing

Sponsored by MSMS for all registrants, exhibitors and for members of the Auxiliary and Medical Assistants

Ala Carte Cocktails

OR LECTURES ABOUT PEDIATRICS, AND PAIN

Ballroom A
(Fourth Floor)

Sponsored by the Section on Pediatrics.

Chairman:
Anthony C. Gholz,
MD, Port Huron

Secretary:
John L. Doyle,
MD, Grand Rapids

2:00 - 3:15

PEDIATRIC PROBLEMS

Program Chairman: William J. Oliver, MD, Professor of Pediatrics and Communicable Diseases and Chairman of the Department of Pediatrics and Communicable Diseases, University of Michigan Medical School

The Management of Respiratory Failure in the Newborn

Leo Stern, MD, Montreal, Canada, Director of the Neonatal Intensive Care Unit, Montreal Children's Hospital; and, Assistant Professor of Pediatrics, McGill University Faculty of Medicine

The Diagnosis and Management of Infections in the Newborn

Joseph V. Baublis, MD, Assistant Professor of Pediatrics, University of Michigan Medical School and Lecturer, School of Public Health

Business Meeting of the Section on Pediatrics

3:15 - 4:00

Intermission to View the Exhibits

Ballroom A

Sponsored by the Section on Anesthesiology and the Michigan Society of Anesthesiologists, Inc.

Chairman:
Shirley Austin,
MD, Detroit

Secretary:
Ralph E. Bauer,
MD, Detroit

4:00 - 5:00

RELIEF OF PAIN

Moderator: Shirley Austin, MD, Detroit

John W. Ditzler, MD, Chicago, Director, Department of Anesthesiology, Chicago Wesley Memorial Hospital; Professor of Anesthesia, Northwestern University Medical School

He will attempt to emphasize that nearly all doctors hear of the complaint of pain daily, that nearly all of us experience "pain" to one degree or another, and that when pain is not ordinarily relieved by the obvious removal of a cause or by standard medications that the difficulties of therapy begin primarily often on an iatrogenic basis. It will be pointed out further that patients with known organic causes for pain frequently develop such serious functional overlays that proper psychotherapy often becomes impossible. Patients frequently rebel and reject the competent services of psychiatrists; physicians who inject various medications into painful areas frequently fail because of an inopportune patient-physician relationship. While not all anesthesiologists desire or are equipped to handle complex problems in the relief of pain, it is, however, suggested that this is an area where the anesthesiologist may provide a service not elsewhere available.

Business Meeting of the Section on Anesthesiology

BOOK CASINO
(Lobby Floor)

5:00 - 6:00

Fireside Discussions with Speakers

ALL REGISTRANTS, WIVES INVITED TO PRESIDENTS PARTY

Wednesday, September 25
Meetings of Sections and Related Groups

10:45 am - 12 noon
Boulevard & Room 615
(Sixth Floor)

Section on Dermatology

Chairman: Ralph J. Cosky, MD, Oak Park
Secretary: Earl J. Rudner, MD, Detroit

Panel presentation on "Oral Mucous Membrane Lesions"

Henry G. Bryan, MD, Detroit, Clinical Instructor, Wayne State University School of Medicine

Myron Kaufman, D.D.S., Detroit, Diplomate, American Board of Oral Surgery; Attending Oral Surgeon, Sinai Hospital

This discussion will deal with common lesions of the oral mucosa, classified according to their most pronounced clinical appearance. It will attempt to assist the clinician in differentiating the various oral diseases that produce white lesions, ulcerative lesions, tumefactions, and so forth. It is hoped that it will also enhance his diagnostic possibilities, so that in examining a lesion, his list of differential diagnoses will be increased.

Edward A. Krull, MD, Physician, Department of Dermatology, Henry Ford Hospital

Amir H. Mehregan, MD, Clinical Assistant Professor of Dermatology, Wayne State University School of Medicine

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12 noon to 2:00 pm
luncheon - meeting
English Room
(Mezzanine)

Section on Plastic Surgery

Chairman: Alexander P. Kelly, MD, Detroit
Secretary: Joseph H. Naud, MD, Detroit

Surgery of the Parotid Gland

Robin Anderson, MD, Cleveland, Head, Department of Plastic Surgery, Cleveland Clinic

All registrants at the Convention are most welcome to attend.

2:00 - 3:15 pm
Washington Room
(Fifth Floor)

Section on Public Health and Preventive Medicine

Chairman: Gordon A. Eadie, MD, Newberry
Secretary: Maurice S. Reizen, MD, Lansing

Medicare and Medicaid — Their Impact
- - - From the Viewpoint of the Medical Care Administrator

Avedis Donabedian, MD, Professor of Medical Care Organization, School of Public Health, University of Michigan

This presentation will deal with the actual and expected impacts of Medicare and Medicaid (mainly the former) on the medical care system as a whole including: Public acceptance and participation, use of service, prices and expenditures, degree of consumer protection, the quality of care, health insurance, hospitals and related facilities and public welfare medical care.

- - - From the Viewpoint of the Private Practitioner

Beverly C. Payne, MD, Ann Arbor, Assistant Dean, University of Michigan Medical School and Clinical Assistant Professor in Internal Medicine, University of Michigan Medical School

4:00 pm meeting
5:30 Reception
Sheraton Room
(Fifth Floor)

Section on Otolaryngology

Chairman: Paul J. Dzul, MD, Detroit
Secretary: Christian Helmus, MD, Grand Rapids

Pediatric Problems in Otolaryngology

Herbert G. Birck, MD, Columbus, Ohio, Clinical Professor Ohio State University, Chief, Department of Otorhinolaryngology, Children's Hospital

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4:00 pm
Mason Room
(Fifth Floor)

Section on Physical Medicine

Chairman: Edwin M. Smith, MD, Ann Arbor
Secretary: George H. Koepke, MD, Ann Arbor

Reception and Organizational Meeting (No Speaker)

4:00 pm meeting
Room 615
(Sixth Floor)

Section on Ophthalmology

Chairman: James L. Frey, MD, Southfield
Secretary: Raymond A. Pinkham, MD, Kalamazoo

"Analysis of Overcorrected Exotropia"

Robert J. McDonald, MD, Royal Oak

4:00 pm
Boulevard Room
(Sixth Floor)

Section on Allergy and Applied Immunology

Chairman: Julius J. Greenberg, MD, Southfield
Secretary: Jack M. Lesesne, MD, Grosse Pointe

Mechanisms of Immunologic Tissue Injury

David Hawkins, MD, Medical Research Council of Canada, Scholar; Assistant Professor of Medicine, McGill University, Montreal, Quebec, Canada

Several experimental models of immunologic disease which bear certain resemblances to human autoimmune and collagen-vascular diseases will be discussed. The elucidation of some of the mechanisms of tissue injury in these experimental models give some insight as to how similar processes could result in human disease. The focal point of the discussion will be the injury to vascular and modified vascular tissues such as the glomerulus.

5:00 pm reception
6:00 pm dinner
Statler-Hilton

Michigan Branch, American Academy of Pediatrics

What's New With Hyperbilirubinemia

Leo Stern, MD, Montreal, Canada

6:00 pm
East Room
(Fifth Floor)
reception

Section on General Practice

Chairman: John M. Battle, MD, Dearborn
Secretary: John M. Jacobowitz, MD, Three Rivers

6:00 pm reception -
7:00 dinner - meeting
English Room
(Mezzanine)

Section on Radiology and The Detroit Roentgen Ray Society

Chairman: Robert S. Ormond, MD, Dearborn
Secretary: Robert A. Songe, MD, Dearborn

Lymphatic System

Manuel Viamonte, Jr., MD, Miami, Florida, Department of Radiology, University of Miami School of Medicine

Thursday Morning, September 26

Choose from Two Concurrent General Sessions

LECTURES ABOUT PROSTATE CARCINOMA

Ballroom A

9:00 - 10:00

PROSTATE CARCINOMA

Moderator: Edward J. Shumaker, MD, Chief, Division of Urology, Harper Hospital and Assistant Clinical Professor, Wayne State University Medical School

George T. Mellinger, MD, Minneapolis, Chief of Urology Service, Veterans Administration Hospital; Chairman, Veterans Administration Cooperative Urological Research Group; and Associate Professor of Urology, University of Minnesota

Presentation of the latest figures and conclusions from the cooperative study on cancer of the prostate by the Veterans Administration Cooperative Urological Research Group.

Willet F. Whitmore, Jr., MD, New York City, Chief, Urologic Service, Memorial Hospital for Cancer and Allied Diseases; Clinical Professor of Surgery (Urology) Cornell Medical College

The natural history of prostatic cancer and the influence of endocrine therapy on the survival of the patients with prostatic cancer.

10:00 - 10:45

Intermission to View the Exhibits

Ballroom B
(Fourth Floor)

Sponsored by
the Section on
Internal Medicine.

Chairman:
John B. Bryan,
MD, Royal Oak

Secretary:
John R. Caldwell,
MD, Detroit

9:00

CARDIOVASCULAR DISEASES

Program Chairman: Richard J. Bing, MD, Professor and Chairman, Department of Medicine, Wayne State University School of Medicine

Pulmonary Embolus

Park W. Willis III, MD, Professor of Internal Medicine, University of Michigan Medical School

9:30

General Pediatric Care in Relation to Prognosis of Infants with Congenital Heart Disease

Charlotte I. Ferencz, MD, Associate Professor of Pediatrics, State University of New York at Buffalo, New York

Cardiac infants need more general care than normal babies. This may make all the difference to the timing and success of corrective surgery and at times the necessity for surgical interference may be avoided. In this day of technical advances the pediatrician and practitioner often feels that only the specialist can contribute significantly to the care of these babies. The major pathophysiologic problems of infants will be discussed, with "warning signs" and guidelines for successful management.

10:00

The Effect of Nicotine and Alcohol on the Heart

Richard J. Bing, MD, Professor and Chairman, Department of Medicine, Wayne State University School of Medicine

Thursday Morning, September 26

Choose from Two Concurrent General Sessions

LECTURES ABOUT CALCIUM

Ballroom A
(Fourth Floor)

10:45 - 12:00

CALCIUM — TOO MUCH - TOO LITTLE

Moderator: Richmond W. Smith, MD, Chairman, Department of Medicine Henry Ford Hospital

The panel will discuss regulatory mechanisms for serum calcium, the causes and significance of hypocalcemia and hypercalcemia, the actions and interactions and parathyroid hormone, calciotonin thyroxin, vitamin D, etc., and the best means to control the severe hypercalcemic state.

Louis V. Avioli, MD, St. Louis, Missouri, Director, Division of Endocrinology, the Jewish Hospital of St. Louis and Associate Professor of Medicine, Washington University School of Medicine.

Robert D. Johnson, MD, Associate Professor of Internal Medicine and Postgraduate Medicine, University of Michigan Medical School.

Boy Frame, MD, Physician-in-Charge, Fifth Medical Division, Henry Ford Hospital

The various mechanisms that control calcium metabolism normally and in various pathalogic states will be discussed with emphasis on recent developments relating to the physiology of parathyroid hormone and thyrocalcitonin.

All registrants are invited to General Luncheon

10:30

Cardioversion

Robert A. England, MD, Boston, Assistant in Medicine, Peter Bent Brigham Hospital, Research Fellow, Harvard School of Public Health

11:00

Round Table Discussion on "Coronary Artery Disease, It's Mechanisms and Treatment"

Topics: The Coronary Care Unit and Its Use
The Treatment of Cardiogenic Shock
The Prevention of Coronary Artery Disease
Epidemiology of Coronary Artery Disease

Discussants:

Moderator: Richard J. Bing, MD, Professor and Chairman, Department of Medicine, Wayne State University School of Medicine

Raymond S. Kurtzman, MD, Associate Professor of Radiology, Wayne State University School of Medicine

Erwin Robin, MD, Assistant Professor of Medicine, Wayne State University School of Medicine

Raymond E. Fuller, MD, Grand Rapids, Chairman, Cardiovascular Laboratory

Jack M. Kaufman, MD, Detroit, Associate Professor of Internal Medicine, Wayne State University School of Medicine; Chief of Cardiology and Internal Medicine, Harper Hospital; Attending Cardiologist, Beaumont Hospital

Leon D. Ostrander, Jr., MD, Associate Professor of Internal Medicine, University of Michigan Medical School

Agustin Arbulu, MD, F.A.C.S., Associate Professor in Surgery, Wayne State University School of Medicine

Business Meeting of the Section on Internal Medicine

12:00 - 2:00

English Room
(Mezzanine Floor)

GENERAL LUNCHEON

Chairman: Alexander J. Walt, MD, Assistant Dean Professor and Chairman, Department of Surgery, Wayne State University School of Medicine

Clinical Organ Transplantation

David Hume, MD, Richmond, Virginia, Stuart McGuire Professor and Chairman, Department of Surgery, Medical College of Virginia

Thursday Afternoon, September 26

Choose from Two Concurrent General Sessions

LECTURES ABOUT DIABETES

Ballroom A
(Fourth Floor)
Joint Meeting
with the Michigan
Diabetes Association

2:00 - 3:15

DIABETES

Moderator: Fred W. Whitehouse, MD, Division of Metabolic Diseases, Henry Ford Hospital

Pathophysiology of Acute Metabolic States in Diabetes

Buris R. Boshell, MD, Birmingham, Alabama, Ruth Lawson Hanson Professor of Medicine and Professor of Medicine of the University of Alabama Medical Center

A discussion of the pathophysiology of ketosis, ketoacidosis, lactic acidosis, and hyperosmolar coma.

Panel Presentation on "Diabetic Coma and the Diabetic in Coma"

Moderator: Fred W. Whitehouse, MD, Division of Metabolic Diseases, Henry Ford Hospital

Panelists:

Buris R. Boshell, MD, Birmingham, Alabama, College of Alabama

John B. Bryan, MD, Royal Oak

Richard D. Hohl, MD, Associate Physician, Division of Metabolic Diseases, Henry Ford Hospital

Lawrence H. Power, MD, Associate Professor of Medicine, Wayne State University School of Medicine

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3:15 - 4:00

Intermission to View the Exhibits

See Page 1164 for "Office Management Seminar"

Ballroom B
(Fourth Floor)

2:00 - 3:15

WHAT'S NEW IN THE PRACTICE OF - - - - ?

Moderator: Alexander J. Walt, MD, Assistant Dean, Professor and Chairman, Department of Surgery, Wayne State University School of Medicine

"- - - - Cardiovascular Diseases"

Richard J. Bing, MD, Professor and Chairman, Department of Medicine, Wayne State University School of Medicine

"- - - - Cancer"

Michael J. Brennan, MD, Medical and Scientific Director, The Michigan Cancer Foundation and Professor of Medicine, Wayne State University School of Medicine

The new developments in cancer chemotherapy, which attempt to utilize combinations of chemotherapeutic agents and knowledge of the fundamental cellular effects of these agents together with information on tumor doubling times and cell cycle times to attain optimal results in clinical cancer work.

"- - - - Transplantation"

David Hume, MD, Richmond, Virginia, Chairman, Department of Surgery, Medical College of Virginia

"- - - - Urology"

George T. Mellinger, MD, Minneapolis, Chief of Urology Service, Veterans Administration Hospital; Chairman, Veterans Administration Cooperative Urological Research Group; and Associate Professor of Urology, University of Minnesota

Willet F. Whitmore, Jr., MD, New York City, Chief, Urologic Service, Memorial Hospital for Cancer and Allied Diseases; Clinical Professor of Surgery (Urology), Cornell Medical College

"- - - - Gynecology"

Samuel J. Behrman, MD, Ann Arbor, Director, Center for Research in Reproductive Biology, University of Michigan and Professor of Obstetrics-Gynecology, Department Obstetrics-Gynecology, University of Michigan Medical School

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3:15 - 4:00

Intermission to View the Exhibits

See Page 1164 for "Office Management Seminar"

Thursday Afternoon, September 26

Choose from Two Concurrent General Sessions

LECTURES ABOUT AGING

Ballroom A
(Fourth Floor)

4:00 - 5:00

PSYCHIATRIC PROBLEMS OF THE AGING POPULATION

Moderator: Lawrence Koltonow, MD, Southfield, Chairman, Committee on Aging, Michigan Society of Psychiatry and Neurology

Speaker: Henry W. Brosin, MD, Pittsburgh, Professor and Chairman, Department of Psychiatry, University of Pittsburgh School of Medicine; Director, Western Psychiatric Institute and Clinic

Discussants:

Lawrence Koltonow, MD
Hubert Miller, MD, Detroit, Member, Committee on Aging, Michigan Society of Psychiatry and Neurology
Marvin Sherman, MD, Detroit, Member, Committee on Aging, Michigan Society of Psychiatry and Neurology
Robert E. Walden, MD, Detroit, Member, Committee on Aging, Michigan Society of Psychiatry and Neurology

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THURSDAY, SEPTEMBER 26

3:00 - 5:30

OFFICE MANAGEMENT SEMINAR

English Room
Mezzaine

Presiding: Norman D. Henderson, MD, East Lansing, Chairman, MSMS Liaison Committee with Residents, Interns and Senior Medical Students

How to Set Up and Run an Efficient Office
C. Allen Willmar, Saginaw, Professional Management

How to Hire and Train Employees
Charles V. Brown, Detroit, Professional Management

To Solo or Not to Solo
John K. Hoffman, Grand Rapids, Professional Management

OR MORE ABOUT "WHAT'S NEW IN THE PRACTICE OF —"

Ballroom B
(Fourth Floor)

4:00 - 5:00

"- - - - G-I Tract Diseases"

J. Edward Berk, MD, Orange, California, Professor and Chairman, Department of Medicine, University of California

"- - - - Infections and Antibiotics"

A. Martin Lerner, MD, Professor of Medicine, Wayne State University School of Medicine

"- - - - Pediatrics"

Charles F. Whitten, MD, Detroit, Associate Professor of Pediatrics and Program Director of The General Clinical Research Center for Children, Wayne State University School of Medicine

"- - - - Endocrine Diseases"

Raymond C. Mellinger, MD, Chief, Division of Endocrinology, Henry Ford Hospital

Precise diagnostic methods for the pituitary hormones by radioimmunoassay and the steroid hormones by iostope displacement assay provide major new tools for endocrine diagnosis. Increasing availability of purified pituitary hormones is the basis for significant improvement in endocrine treatment. These advances in diagnosis and treatment will be discussed in terms of specific glandular disorders.

Continuation of Seminar Program:

What Shall I Do with the Money I Earn?

R. Timothy Hogan, Ann Arbor, Professional Management

A New Billing and Collection Plan

Carl G. King, Jr., Saginaw, The Doctors' Business Bureau

Social Hour, Sponsored by MSMS, to Follow

(The Seminar is made possible by a grant from the Merck, Sharp and Dohme Postgraduate Program)

Meetings of Sections and Related Groups

Thursday

9:30 am
Washington Room

Section on Pathology and The Michigan Society of Pathologists

Chairman: Murray R. Abell, MD, Ann Arbor
Secretary: Edwin M. Knights, MD, Southfield

Business Meeting

Woodward Room

Luncheon

1:30 - 5:00 pm
Woodward Room
(Fifth Floor)

Slide Seminar on Diseases of Skeletal Muscle

William K. Engel, MD, Bethesda, Md., Chief Medical Neurology Branch, N.I.N.O.B. and National Institutes of Health

6:30 pm
Book Casino

Cash Bar

7:00 pm

Past Presidents Dinner

10:00 am to 12:00
Noon Meeting
Sheraton Room
(Fifth floor)

Section on Occupational Medicine

Chairman: Richard W. Prior, MD, Flint
Secretary: Paul E. Derleth, MD, Ferndale

Capacitance Respirometry — A New Method of Measuring Lung Impairment

Robert E. Barrow, Ph.D., Detroit, Postgraduate Fellow, U.S.P.H.S.

A new and simple method has been devised which measures pulmonary volumes and flow rates without the added errors due to the friction and air flow resistance of conventional respirometers. The capacitance respirometer detects changes in the surface area of the rib cage and abdomen during respiration and these data are recorded as respiratory volumes. Pulmonary function data are quickly obtained with a minimum of psychological error. This method has the further advantage of permitting measurements while the subject is fully dressed.

The volumes (T.V., E.R.V., I.R.V.), capacities (V.C., I.C.) and flow rates now measured by conventional instrumentation can be accurately measured and recorded with this technique.

2:00 pm
Washington Room
(Fifth Floor)

Section on Thoracic Surgery

Chairman: Cameron Haight, MD, Ann Arbor
Secretary: Raymond J. Barrett, MD, Detroit

2:00 pm

Business Meeting

2:30 pm

A Practical Approach to Carcinoma of the Lung

Lyman A. Brewer III, MD, Clinical Professor of Surgery, University of California

Carcinoma of the lung, the most common cancer in males, is increasing at an alarming rate and has passed pulmonary tuberculosis as a cause of death. From analysis of a large series of personal cases it is certain that early detection and resection currently offer the best opportunity for long-term survival of the patient. Since bronchoscopy is diagnostic in only 25% of the patients, early detection depends upon correct interpretation of chest roentgenograms and proper follow-up investigation. The author's topographical classification of carcinoma of the lung which consists of main bronchus, 24%; lobar bronchus, 54%; midlung and subpleural, 11% each, offers a practical approach to early recognition. The discussion will cover diagnosis and treatment and define the role of thoracotomy. Of the patients who have had pulmonary resection, 50% of the midlung, approximately 25% of the lobar and main bronchus, and 10% of the subpleural resections have had "5-year cures".

4:00 pm
Scientific Meeting

5:30 Reception

6:30 Dinner
Sheraton Room
(Fifth Floor)

Section on Orthopedic Surgery and the Michigan Orthopaedic Society

Chairman: H. Ross Hume, MD, Detroit

Secretary: George D. Stilwill, MD, Lansing

Studies on Trunk Growth in Normal Children and in Children with Growth Disorders

Ignacio V. Ponseti, MD, Iowa City, Professor of Orthopedic Surgery, The University of Iowa, Department of Orthopedic Surgery

Following the growth spurt of infancy, the growth rate of the extremities is fairly constant until maturity, where as the growth rate of the trunk decreases gradually until ten to twelve years of age, and then increases until sixteen years of age. The increase in growth rate in the spine and pelvis but not in the long bones, during adolescence, is related to the difference in structure of the growth plates of the vertebrae and pelvis, and the long bones.

The iliac crest is histologically similar to the vertebral rim; both ossify simultaneously and both may be considered special types of traction epiphysis or apophysis. Histological and chemical studies of iliac crest cartilage in normal children and in children with growth disorders such as achondroplasia, multiple epiphyseal dysplasia, Morquio's disease, and idiopathic scoliosis will be reported.

5:30 pm
reception and
6:30 - dinner
Boulevard Room and
Room 615
(Sixth Floor)

Section on Neurological Surgery and The Michigan Association of Neurological Surgeons

Chairman: Austin E. Lamberts, MD, Grand Rapids

Secretary: Philip J. Huber, MD, Royal Oak

The Neurosurgeon and Blue Shield

Neal L. McCue, Detroit, Vice President of Professional Relations, Michigan Blue Shield

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6:00 pm reception -
dinner - meeting
Woodward Room
(Fifth Floor)

Section on Psychiatry and Neurology and The Michigan Society of Psychiatry and Neurology

Chairman: Glenn G. Golloway, MD, Ann Arbor

Secretary: Henry Krystal, MD, Southfield

Program Chairman: Allen J. Enelow, MD, East Lansing, Professor and Chairman, Department of Psychiatry, Michigan State University

American Medicine and the Development of an American Style in Psychiatry

Professor John C. Burnham, Columbus, Ohio, Department of History, Ohio State University

A historical survey of the development of trends in American Psychiatry since about 1890, with an emphasis on the interplay between the science of psychiatry and its medical and institutional environment.

Discussant: Allen J. Enelow, MD

All-Day Postgraduate Course

Wednesday, September 25, 1968
Course on "Infectious Diseases"

East Room
Fifth Floor

8:45 *Moderator: A. Martin Lerner, MD, Professor of Medicine, Wayne State University School of Medicine*

9:00 - 9:45 **New Virus Vaccines (Respiratory, Measles, Mumps)**

Jerome O. Klein, MD, Assistant Professor of Pediatrics, Harvard Medical School; and Associate Director, Department of Pediatrics, Boston City Hospital

10:00 - 10:45 **The Extended Rubella Syndrome and Its Prophylaxis**

Mary M. Carruthers, MD, Associate in Medicine, Chicago Medical School, Mt. Sinai Hospital Medical Center

11:00 - 11:45 **Interferon and Its Clinical Application**

Thomas C. Merigan, MD, Palo Alto, Associate Professor of Medicine, Chief, Division of Infectious Diseases, Stanford University School of Medicine, Stanford Medical Center

Recovery from virus infections seem to involve several facets of host defense including antibodies, phagocytosis, interferon and the local tissue responses (acidity, heat, etc.). One of these factors, interferon, which is non-toxic but has a broad antiviral spectrum, may be useful in protecting against certain common virus infections which are caused by a wide variety of agents. Because only small amounts of interferon are available from natural sources, we have turned from its purification to a study of agents, to induce humans to make their own interferon. We have explored the action of several of these agents in man including naturally accurring and vaccine strains of human viruses, a highly attenuated animal virus not pathogenic for man, and a synthetic polycarboxylate polymer. The interferon response with each was defined and related to levels we had previously found to be active in protecting man from virus infection. Our studies will be discussed in relationship to those reported from the USSR suggesting clinical cures, with interferon induction in virus infection of respiratory tract, eye and skin. We conclude that interferon inducers have promise in prophylaxis and therapy of virus infection in man.

Luncheon Break

Continued: Course on "Infectious Diseases"

Afternoon Session *Moderator: Harry F. Dowling, MD, Chicago, Professor and Head, Department of Medicine, University of Illinois College of Medicine*

2:00 - 2:45 Antiviral Chemotherapy

Jerome A. Gold, MD, Philadelphia, Research and Development Division, Smith Kline & French Laboratories; and Clinical Assistant Professor of Medicine, Woman's Medical College of Pennsylvania

3:00 - 3:45 New Antibiotics Versus Gram-Negative Infections Including the Penicillins, Cephalosporins, Tetracyclines, and Gentamycin

Edward L. Quinn, MD, Chairman, Division of Infectious Diseases, Department of Medicine, Henry Ford Hospital

The increasing role of gram-negative infections, particularly in hospitalized patients, has been associated with the development of new antibiotics effective against these organisms. These include the broad-spectrum penicillins — ampicillin, active against many strains of *E. coli* and *Proteus mirabilis* and carbenacillin, a penicillin with increased pseudomonal activity. The synergistic effect of a combination of a penicillinase resistant penicillin, such as cloxacillin, with a penicillinase susceptible penicillin, such as ampicillin, has been demonstrated in pseudomonal urinary tract infections.

The two cephalosporins currently available must be administered by parenteral injection and have activity against coliform organisms and certain strains of Proteus. Cephalosporin derivatives effective after oral administration and active against similar gram-negative organisms are under development.

Alteration in the tetracycline molecule has resulted in compounds with prolonged activity and increased spectrum.

A new agent belonging to the basic, water soluble group of antibiotics of which neomycin and kanamycin are the prime examples, is gentamycin, a broad spectrum antibiotic with a high degree of activity against many gram-negative species, particularly Proteus and *Pseudomonas* sp.

4:00 - 4:45 Special Toxicities of Older Antibiotics, Tetracycline, Kanamycin, Colistin

Frank Cox, MD, Associate Physician, Division of Infectious Diseases, Henry Ford Hospital

Prolonged experience with certain of the older antibiotics — Tetracycline, Kanamycin, and Colistin — have brought to light certain adverse effects of these agents not originally appreciated. These, together with the well recognized reactions to these agents, must be considered in their use.

Tetracycline has been employed for many years and a number of adverse effects have been noted to be associated with its administration. These include gastrointestinal effects of nausea and diarrhea seen with declining frequency recently; the staining and mottling of teeth in infants and children; the antianabolic effect in persons with renal insufficiency; and, sudden death reported in certain people receiving large doses intravenously.

Kanamycin, when first developed, was used primarily as an antistaphylococcal agent; and, as such, was employed in large doses. Toxicity at that time was seen more frequently than at present, when more modest doses are utilized. However, ototoxicity and nephrotoxicity are still observed, particularly in older patients or those with renal insufficiency.

Colistin, closely related to polymyxin B demonstrates much the same type of toxicity. Transient paresthesias, vertigo, and ataxia are seen to be, in part, dose related. Renal toxicity has also been noted in a few patients and is more marked in patients with low renal reserve.

These well established and useful antimicrobial agents thus have potential for serious and even fatal side effects. As with any potent drug, knowledge of these side effects and measures to reduce their occurrences are essential.

All-Day Postgraduate Course

Wednesday, September 25, 1968
Course on "Pulmonary Diseases"

West Room
Fifth Floor

Chairman: Geoffrey L. Brinkman, MD, Associate Professor of Medicine, Wayne State University School of Medicine

Morning Session

Moderator: Benjamin M. Lewis, MD, Professor of Medicine, Wayne State University School of Medicine

8:45 **Management of Respiratory Failures**

Clinical Manifestation

Kaye H. Kilburn, MD, Durham, Associate Professor of Medicine, Duke University Medical Center

Followed by ten-minute discussion

9:10 **Physiology of Respiratory Failure**

Benjamin M. Lewis, MD, Professor of Medicine, Wayne State University School of Medicine

Followed by ten-minute discussion

9:40 **Treatment**

Techniques for Cleansing and Securing the Airway

Kaye H. Kilburn, MD, Durham, Associate Professor of Medicine, Duke University Medical Center

The discussion will include descriptions of the anatomy of physiology of clearance of the normal tracheobronchial tree. The elements of the mucociliary escalator and how they work; the disturbing effects of acute bronchitis, chronic bronchitis and pulmonary emphysema on this orderly mechanism, will be discussed. Next is an outline of therapy to restore, improve or enhance normal mechanisms. This is followed by methods for taking over airway function both as to clearance and for supporting ventilation. Practical and simple methods stressing fundamental good treatment will be emphasized.

The medical therapy of pulmonary embolism will be approached from the basis of understanding the functions of the pulmonary circulation and its control. It serves as a blood reservoir, a reserve of white blood cells, a biochemical factory, a distribution system and a filter for the entire blood flow. As a filter, it has the function of removing aggregates of cells until they can be broken up. A 16 mm movie strip will be shown to illustrate this function and how drugs such as heparin, low molecular weight dextran, protamine, polybrene, high molecular weight dextran and agents such as histamine, acetylcholine, morepiniphrine and isoproterenal affect small emboli. The clinical applicability of such information will be discussed.

10:20 **Assisted Ventilation**

Gordon L. Snider, MD, Professor of Medicine, Boston University School of Medicine

Correction of hypoxemia and maintenance of alveolar ventilation are essential in the successful management of respiratory failure. Methods of monitoring, techniques of control, oxygen administration and artificial assistance to ventilation will be covered.

Followed by ten-minute discussion

11:00 **Ambulatory Care**

Thomas L. Petty, MD, Denver, Associate Professor of Medicine, University of Colorado Medical Center

Followed by ten-minute discussion

11:30 *Panel Discussion: Kaye H. Kilburn, MD; Benjamin M. Lewis, MD; Thomas L. Petty, MD; Gordon L. Snider, MD; and Rodman E. Taber, MD*

Luncheon Break

Continued: Course on "Pulmonary Diseases"

Afternoon Session — *Moderator: Geoffrey L. Brinkman, MD, Professor of Medicine, Wayne State University School of Medicine*

Pulmonary Embolism

2:00 **Diagnosis — Clinical**

Thomas L. Petty, MD, Denver, Assistant Professor of Medicine, University of Colorado Medical Center

2:15 **Diagnosis — Radiological**

Manuel Viamonte, MD, Department of Radiology, University of Miami School of Medicine

Followed by fifteen-minute discussion

2:45 **Therapy — Medical**

Kaye H. Kilburn, MD, Durham, Associate Professor of Medicine, Duke University Medical Center

3:00 **Therapy — Surgical**

Rodman E. Taber, MD, Associate Surgeon, Division of Thoracic Surgery, Henry Ford Hospital

This will be a demonstration of cases showing cardiac catheterization and angiographic data. Case selection for pulmonary embolectomy will be discussed. Prevention of pulmonary embolism will be presented with emphasis on vena caval ligation and clipping. The disturbed physiology produced by vena caval ligation will be presented.

Followed by fifteen-minute discussion

Acid-Fast Infections

3:45 **Atypical Acid-Fast Infections**

Gordon L. Snider, MD, Professor of Medicine, Boston University School of Medicine

A significant proportion of admissions to hospitals for tuberculosis are due to infections with non-human or atypical mycobacteria. Intensive bacteriological studies have resulted in a better understanding of classification, identification, and epidemiology of these infections. Because of their resistance to the standard antituberculous drugs, chemotherapy requires a special approach. Representative cases will be presented.

Followed by five-minute discussion

4:20 **Prophylactic Anti-Tuberculous Chemotherapy**

Winthrop N. Davey, MD, Professor of Internal Medicine, University of Michigan School of Medicine

Followed by ten-minute discussion

All-Day Postgraduate Course

Thursday, September 26, 1968
Course on "Blood Diseases"

East Room
Fifth Floor

8:45 *Moderator: Arnold R. Axelrod, MD, Associate Professor of Clinical Medicine, Wayne State University; Chief, Hematology Division, Department of Medicine, Sinai Hospital; Consultant in Hematology, Providence and Mt. Carmel Hospitals*

9:00 **Orientation to Anemia**

Julius Rutzky, MD, Associate Professor of Pathology, Wayne State University School of Medicine

10:30 Coffee Break

11:00 **An Approach to Hemolytic Anemias**

Scott N. Swisher, MD, East Lansing, Chairman, Department of Medicine, Michigan State University College of Human Medicine

The general indicators of hemolytic processes, both primary and secondary will be discussed. The Characteristics of the most common congenital and acquired hemolytic disorders will be treated briefly and the general principal relating to the management of these problems will be considered in the light of the pathological and physiological involvement of the role of blood transfusion of that particularly emphasized.

12:30 Luncheon Break

2:15 **The Leukocytes — Differential Patterns and Relations to Leukemia**

George Clifford, MD, New York City, Director, Medical Laboratory Service, Sloan Kettering Institute

3:30 Coffee Break

4:00 **An Orientation of Platelet Diseases**

Arnold R. Axelrod, MD, Associate Professor of Clinical Medicine, Wayne State University School of Medicine; Chief, Hematology Division, Department of Medicine, Sinai Hospital; Consultant in Hematology, Providence and Mt. Carmel Hospitals

All-Day Postgraduate Course

Thursday, September 26, 1968
Course on "Difficult Decisions in Digestive Diseases"

West Room
Fifth Floor

8:45 - 5:00

Moderator: William S. Haubrich, MD, Division of Gastroenterology, Henry Ford Hospital

Guest Experts

J. Edward Berk, MD, Orange, California, Professor and Chairman, Department of Medicine, California College of Medicine

Melvin A. Block, MD, Chief, Division V, Department of General Surgery, Henry Ford Hospital

The surgical management of certain difficult problems involving diseases of the digestive tract will be discussed.

Alfred S. Frosbese, MD, Abington, Pennsylvania, Associate Professor of Surgery, School of Medicine, University of Pennsylvania; Chief of Staff and Director of Surgery, Abington Memorial Hospital

Special Contributors

"An Ileo-Colitis Problem"

Eugene A. Gelzayd, MD, Clinical Instructor, Department of Medicine, Wayne State University School of Medicine; Associate, Internal Medicine, Providence Hospital

Discussion of diagnosis and treatment of the inflammatory bowel diseases with special emphasis on ulcerative colitis and granulomatous colitis — ileocolitis syndromes.

A Liver Problem

Keith S. Henley, MD, Associate Professor of Internal Medicine, University of Michigan School of Medicine

A Puzzling Pancreaticoduodenal Problem

Ramon R. Joseph, Assistant Professor of Internal Medicine, University of Michigan School of Medicine; Director of Gastroenterology, Wayne County General Hospital

A Complicated Duodenal Ulcer Problem

William G. O'Driscoll, MD, Grand Rapids, Chairman, Department of Internal Medicine, St. Mary's Hospital; Consultant, Department of Internal Medicine, Providence Hospital

Multiple Manifestation of Hiatal Hernia

Joseph A. Rinaldo, Jr., MD, Director of Research, Mt. Carmel Hospital

The presentation will emphasize that adequate examination of the patient with esophageal symptoms now includes not only radiography and endoscopy but physicology as well. The patient to be presented will illustrate all of the nuances of this problem.

A Perplexing Gastric Lesion

Bernard M. Schuman, MD, Associate Physician, Division of Gastroenterology, Henry Ford Hospital

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For 1968 Annual Session

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> *—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

Special "Ars Medica" Exhibition Being Brought to Detroit as Feature For MSMS 1968 Annual Session

BY ELLEN SHARP
CURATOR OF GRAPHIC ARTS
DETROIT INSTITUTE OF ARTS

Ars Medica is the title of an exhibition of prints depicting medical subjects which will be shown at The Detroit Institute of Arts from September 22 through October 20, 1968. This exhibition has been arranged in cooperation with the Institute's Department of Graphic Arts and a special committee of physicians especially for the 1968 Annual Session of the Michigan State Medical Society in Detroit, September 25-26.

The exhibition will consist of over 130 original works of art representing all types of graphic media—woodcuts, engravings, etchings, lighographs and serigraphs. The prints are grouped in 21 different categories.

SOME OF THE subjects covered are Hospitals in Peace and War, Hygiene and Preventive Medicine, Medical Teaching, The Madhouse, and Allegories of the Healing Arts.

One of the earliest prints in the exhibition is a woodcut from Ketham's *Fasciculus Medicinae* published in Venice in 1493. Entitled "The Zodiac Man" it is the oldest printed bloodletting chart.

A fine impression of the first etching by the great German graphic artist, Albrecht Durer, *Plate of Sketches,* depicts the four temperaments (or dominant humors) — the choleric, sanguine, melancholic and phlegmatic.

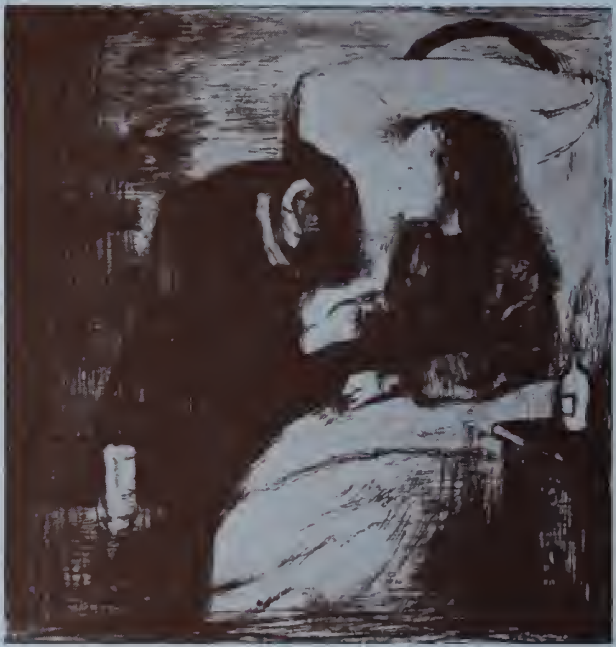
A Sixteenth-century etching by Abraham Bosse illustrates one of the commonest therapeutic measures of that era — phlebotomy. This print is characteristic of Bosse's work showing the life of the upper middle class in France with a wealth of detail.

A pioneer example of color printing, developed in the Eighteenth century, is Jacques Gautier Dagoty's mezzotint *Muscles of the Head,* plate I from *L'Anatomie de la Tete,* Paris, 1748.

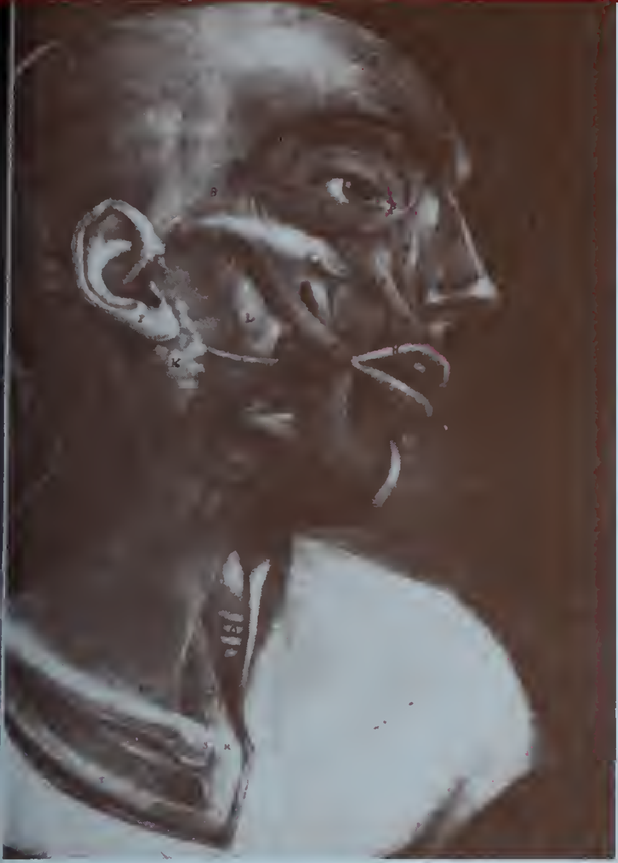
The great caricaturists and humorists of the eighteenth and nineteenth centuries did not neglect the medical profession. Thomas Rowlandson, George Cruikshank, James Gillray, Gavarni, and Honore' Daumier are represented in the exhibition.

Moving and powerful works by modern artists with medical themes are prints by Edvard Munch, Kathe Kollwitz and Michael Mazur.

SOME OF THE MOST interesting prints in the exhibition are portraits of great physicians of the past, such as Paracelsus, Ambroise Pare', Andreas Vesalius, William Harvey, and Carolus Linnaeus.

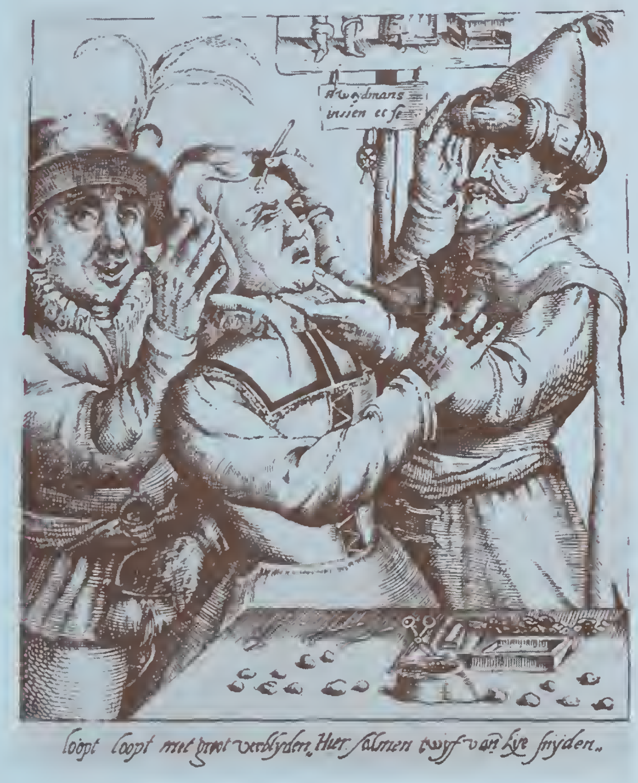


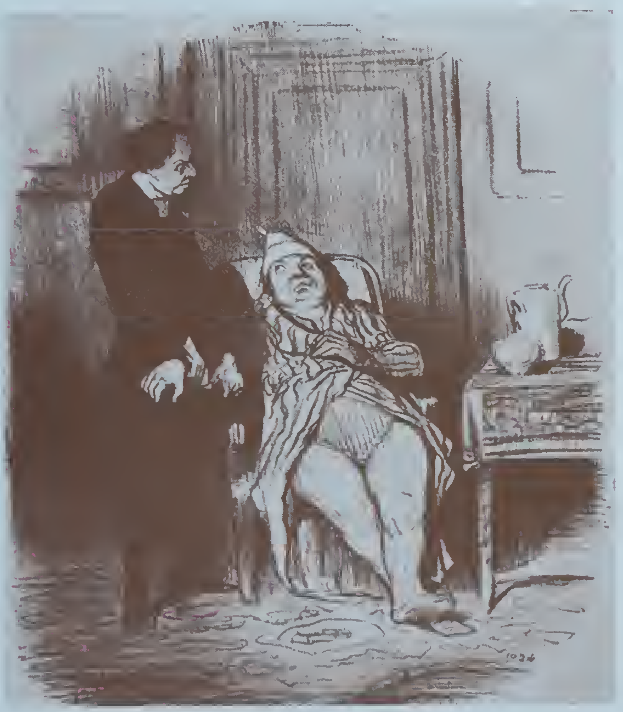
The Sick Child 1894, a drypoint, was made by Edward Munch (Norwegian, 1863-1944). Drypoint is a process often combined with engraving and etching. A metal tool with a tapered point is used to scratch the design on the plate. The burr raised on the plate on each side of the line created by the drypoint tool produces a soft, blurred line quite different from the sharp, swelling line of the engraver's burin, or the flowing, thread-like etched line.



The Muscles of the Head, plate I of **L'Anaotomie de la Tete,** Paris, 1748, is a mezzotint printed in color by Jacques Gautier D'Agoty. A mezzotint is a print produced by a variant of the engraving process, developed to produce tone. A metal plate is roughened uniformly with a tool called a rocker which has a curved, serrated head; gradations of tone are obtained by scraping and burnishing away the roughened surface. The process, invented in the seventeenth century, was used extensively in the eighteenth century.

Operation for Stones in the Head, an engraving, was done by H. Weydmans (Dutch, early 17th Century). An engraving is a print taken from a metal plate on which the design has been incised with a sharp instrument, the burin or graver. The incised plate is inked, wiped and printed. The successful printing of a metal plate requires the pressure of a double-roller press to force the paper into the incised, inked lines.


H.weydmans
inven et fe
loopt loopt met groot verblyden, Hier ſalmen twyf van kye ſnyden.



"Oh Doctor, I'm sure I'm consumptive" says the patient in this lithograph by Honore' Daumier (French 1808-1879). This appeared in a series **All One Could Wish For (Tout ce qui' on voudra),** Paris, 1847. Lithographs are made from a stone block (or zinc plate) on which the areas of the design have been drawn with a greasy substance applied by pen, brush or crayon. The design then is fixed in the stone by treating it with acid and gum arabic. For printing the surface of the stone is dampened and then rolled with greasy ink. The greasy ink adheres to the grease of the image and is repelled by the dampness from the rest of the surface. The inked stone is then printed in a press in which sliding pressure is applied rather than rolling pressure as in an etching press. For color printing, a separate stone is used for each color.

Offer AAGP Credit For Attendance

Members of the Michigan Academy of General Practice will receive credit for each hour they attend the 1968 Annual Session. Application for approval should be made to James Dooley, MD, Chairman, Commission on Education, 3210 S. Dort Highway, Flint.

Read Inside Pages for Topics, Speakers For Annual Session, September 25-26

It's that time of year again!

Yes, that very important time, the season for the MSMS Annual Scientific Session, September 25-26 in Detroit.

In this 103rd year of the Society, MSMS officials and staff are working to surpass previous scientific sessions by presenting an even greater array of programs and exhibits. In addition to the fine opportunity for postgraduate education, physicians will have a chance to renew old friendships and make new ones through alumni groups and other social activities.

Every MSMS member is urged by MSMS President Bradley M. Harris, M.D., to decide now to participate in the excellent postgraduate experience. Doctor Harris praises the work of the Annual Scientific Session Program Committee and Alexander J. Walt, M.D., Detroit, the chairman.

Following tradition, the Scientific Session will follow the three-day meetings of the MSMS House of Delegates, September 22-23-24.

Study this copy of the excellent 1968 Annual Scientific Session.

See you there. . .

Among the Highlights On Detroit Program

The highlights of the 1968 Annual Session include:

Four Breakfast Roundtables
Four All-Day Courses
Two General Luncheons with Speakers
 on "Drugs, Doctors, Government" and
 "Organ Transplantation"
General Assembly Programs
Many MSMS Section Programs
Medical Specialty Society Events
MDPAC Breakfast
Office Management Seminar
Presidents Party
"Ars Medica Art Exhibit"
Educational Exhibits
And Many Other Highlights

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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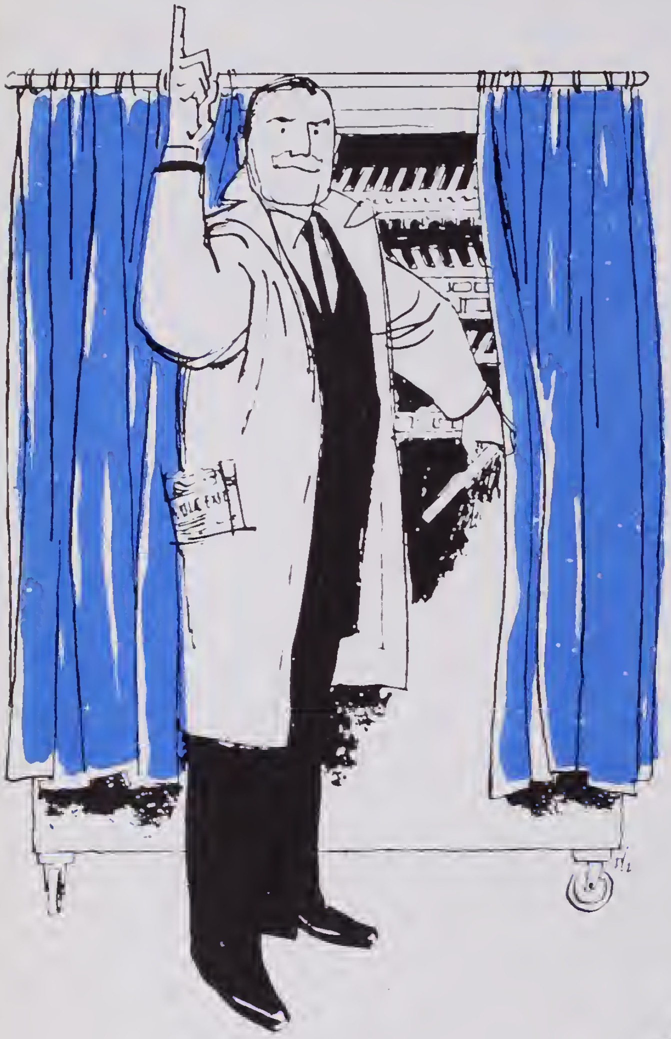
Marjorie Peebles Meyers, M.D.,
Honored As
"Outstanding Physician of the Year"

MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 19
OCTOBER, 1968

AMONG THE EXCELLENT ARTICLES INSIDE:
- —GENETIC FACTORS IN PHYSICAL GROWTH AND DEVELOPMENT
- —SEVERE ASTHMA IN CHILDREN
- —SOLUTIONS SOUGHT IN AIR POLLUTION
- —ADVICE ON YEAR END TAX PLANNING
- —HEALTH PLATFORMS OF POLITICAL PARTIES

. . . but Doctor, will he represent your interests?

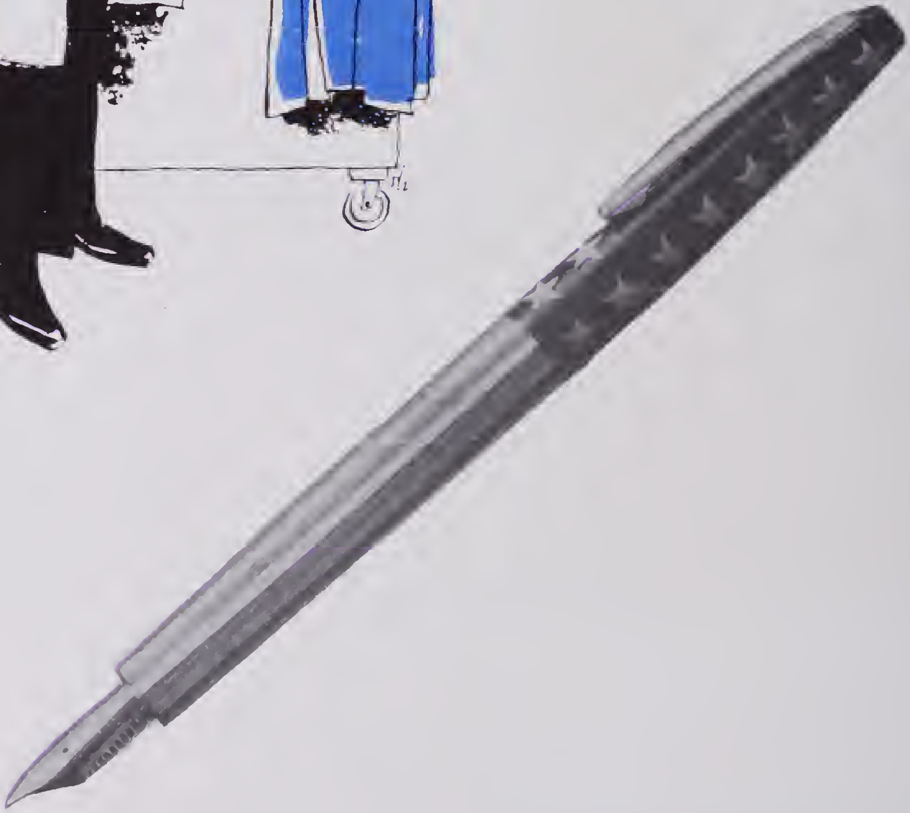


Approximately 2,000 bills of interest to medicine were introduced in the U.S. Congress this year, as were over 150 health bills in the Michigan Legislature.

The responsibility for endorsing, financing and helping to elect wise, dependable political candidates who will listen to the views of the medical profession before voting, rests primarily upon MDPAC and AMPAC.

The MDPAC board is currently assessing the voting record of all legislators and will financially support on a bipartisan basis over sixty candidates for the 1969 legislature. Several members of the Michigan delegation to the Congress have likewise been recipients of MDPAC funds. Much more help is needed. MDPAC has doubled its membership in 1968, and is now approaching 30% of MSMS membership.

MDPAC's effectiveness could develop into a brilliant political success story. It needs your help to accomplish this, and in the 1968 election year a membership of at least a third of Michigan doctors is essential. For twenty-five dollars you can become a member of both AMPAC and MDPAC. MDPAC can only succeed in doing an effective job of campaigning in ratio to the amount of financial help it receives from doctors of medicine.



May we urge you to assume your political responsibility as a contributing member of MDPAC-AMPAC. Help us to elect and retain the best men we can get in office both in Lansing and Washington!

The MSMS House of Delegates and The Council endorse, encourage, and strongly recommend that every Michigan doctor of medicine become a member of MDPAC and AMPAC. CONTRIBUTIONS ARE NOT DEDUCTIBLE ON FEDERAL INCOME TAX RETURNS.

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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MICHIGAN MEDICINE

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OCTOBER, 1968 • VOLUME 67 • NUMBER 19

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THE COVER

This month the cover recognizes Marjorie Peebles Meyers, M.D., who was selected by the 1968 House of Delegates as the "Outstanding Physician of the Year." See pages 1243, 1244, and 1245 for additional photographs and a feature article.

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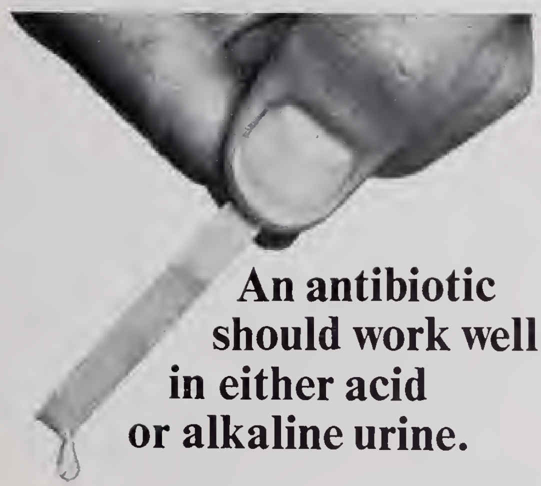

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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BY JAMES J. LIGHTBODY, M.D.

MSMS PRESIDENT'S MESSAGE

Observations about Complications

The changing of the guard has again been accomplished and as your President for the next twelve months it will be my privilege, honor and pleasant duty to present a monthly page or two of delectable composition concerning computerized health and other matters of mutual concern in these United States and particularly in our own state of Michigan.

The understatement of the year is that—"the practice of medicine is changing rapidly and is becoming much more complicated"—as anyone who is in anyway associated with the direct care of patients in or out of hospitals, knows—but actually these incessant changes in medical practice, started many years ago with the introduction of health insurance in all of it's forms. Don't blame Medicare and Medicaid for all of the difficulties one encounters in medical practice today. All that these programs have done is to add a few more frustrating daily experiences to your already heavy load of past frustrations.

UNFORTUNATELY, ALONG with this great influx of new complicated printed forms and new rules and regulations of hospital medical practice, there has already appeared on the horizon the philosophy of depersonalization of the patient-physician relationship—mainly because physicians cannot possibly spend the time as they used to—listening patiently to the complaints of people and trying to figure out whether the complaints are based on physical defects or psychosomatic symptoms of a functional or emotional nature.

There is no substitute for the face to face confrontation of the patient with a physician and the computerized analysis of symptoms followed by a quick view of the patient on direct hospital or office television cannot possibly give the patient anything but a feeling of insecurity.

THE PROBLEM, OF COURSE, revolves around two facts—the increasing number of people demanding medical care and the decreasing number of physicians to service those patients who have specific physical complaints or who are looking to someone for a "checkup." About 70% of patients seen in routine office practice, do not have a physical basis for their symptoms—but if the philosophy of preventive medicine is to be continued, it will be necessary for someone to examine these people to detect latent disease or possible early malignancy.

We are without question entering a new era in which the long established and very personal relationship between patient and Doctor is in jeopardy. Modern medicine is broadly based with a variety of specialists, both professional and non-professional trying to co-operate in the care of a single patient. In most instances an outside agency pays the bill. How, in this complex relationship we are to preserve some semblence of stability, should be a matter of deep concern to all of us.

ANOTHER DISQUIETING thought that will cause a further shortage of physicians, is the fact that Doctors are now retiring at an earlier age because of overwork or because of physical ailments, brought on by overwork. Various types of so-called "Group Practice" are developing to alleviate some of the problems previously associated with solo practice, so that group responsibility may lessen the physican strain and drain on individual practitioners.

Health legislation has created a great demand for physician's services, but legislation is unable to cope with the problem of professional manpower shortage. Good health cannot be legislated; we can work with government — but not for it.

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May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Magan is a new salicylate product from Warren-Teed.

A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

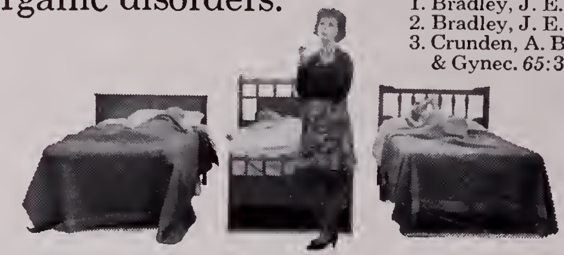
Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.

Dosage: 1 or 2 tablets every 4 hours with a full glass of water.

Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

INGRAM'S SERVICE DEPARTMENT

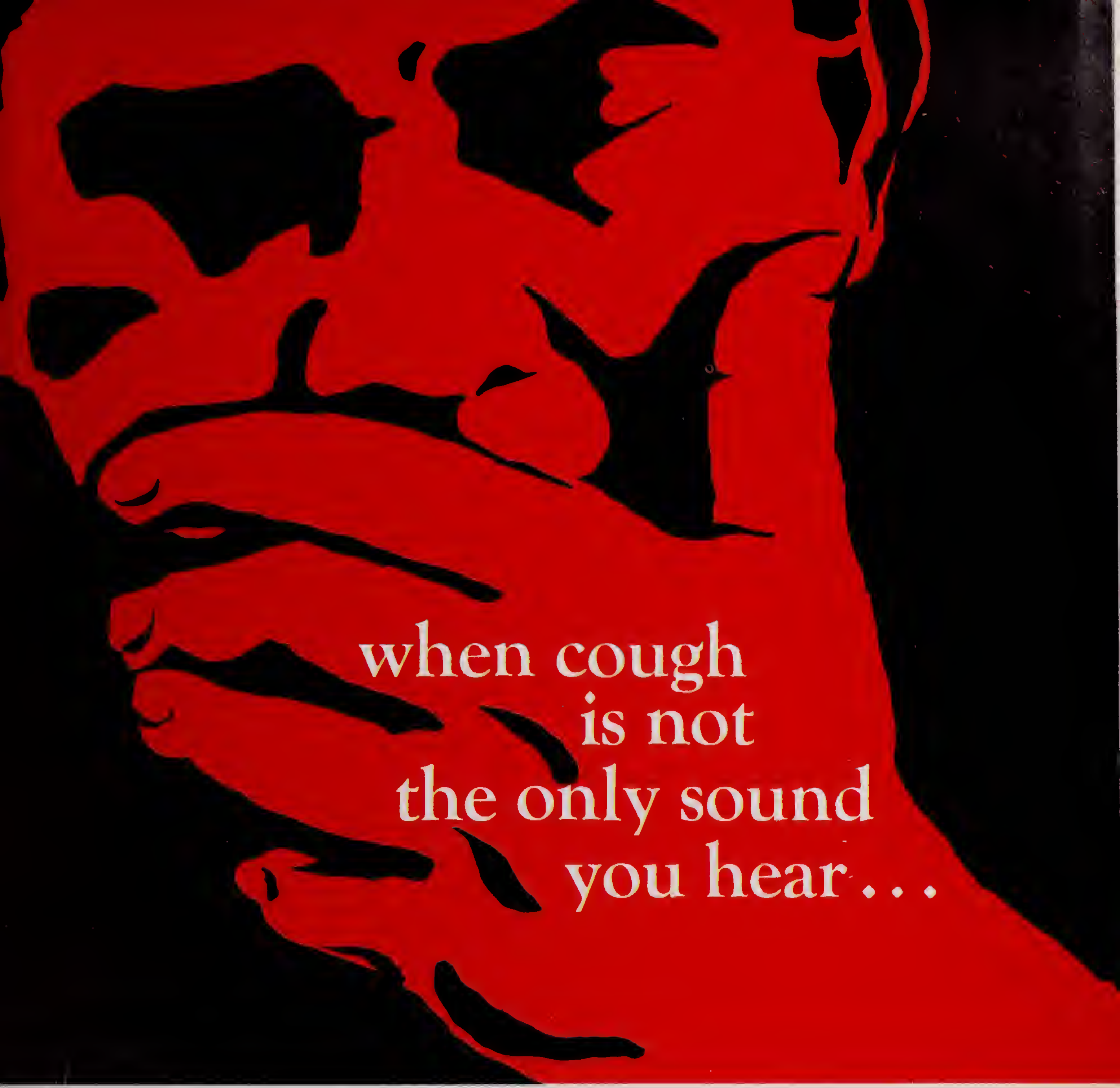
ALL FACTORY TRAINED MEN

We service Medical Equipment, Electrocardiographs, Basal Metabalors, Sterilizers, Autoclaves, Diathermy Outfits, Cutting Units, Ultra Violet Lamps, Hydro Therapy Units, Laboratory Equipment. ALL BURDICK, LIEBEL FLARSHEIM AND RITTER EQUIPMENT.

If you have any Service problems, please call us at TE 2-4444, ask for the SERVICE DEPARTMENT and we will gladly help in any way we can.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue TEmple 2-4444 Detroit, Michigan 48201



OMNI-TUSS® b.i.d.

. . . because OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril
(Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-1

BENADRYL in '68

choose an experienced candidate–
millions of doses prescribed

Benadryl®

(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

No two women are quite alike...

Ovulen-21 Com
Directions

and no other oral contraceptive is quite like Ovulen-*21*®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

"Breathing's a snap again," he said gingerly.

(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A-H-ROBINS

in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

on call...
Keflin®
Sodium
Cephalothin
Eli Lilly and Company
Indianapolis, Indiana 46206

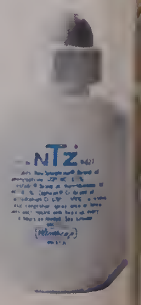
"The inconvenience of a cold"

For a cold: NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains
- Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.
- Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.
- Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

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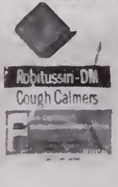
* 1904 - 1967

BETTMAN ARCHIVE
Gotta make a pit stop to take my cough syrup.
Full speed ahead, Fred. These solid Cough Calmers can control that cough for 6 to 8 hours.
2



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")

A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Is it depression?

He says "It's my stomach..."

...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt
strongly suggest
an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl

(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

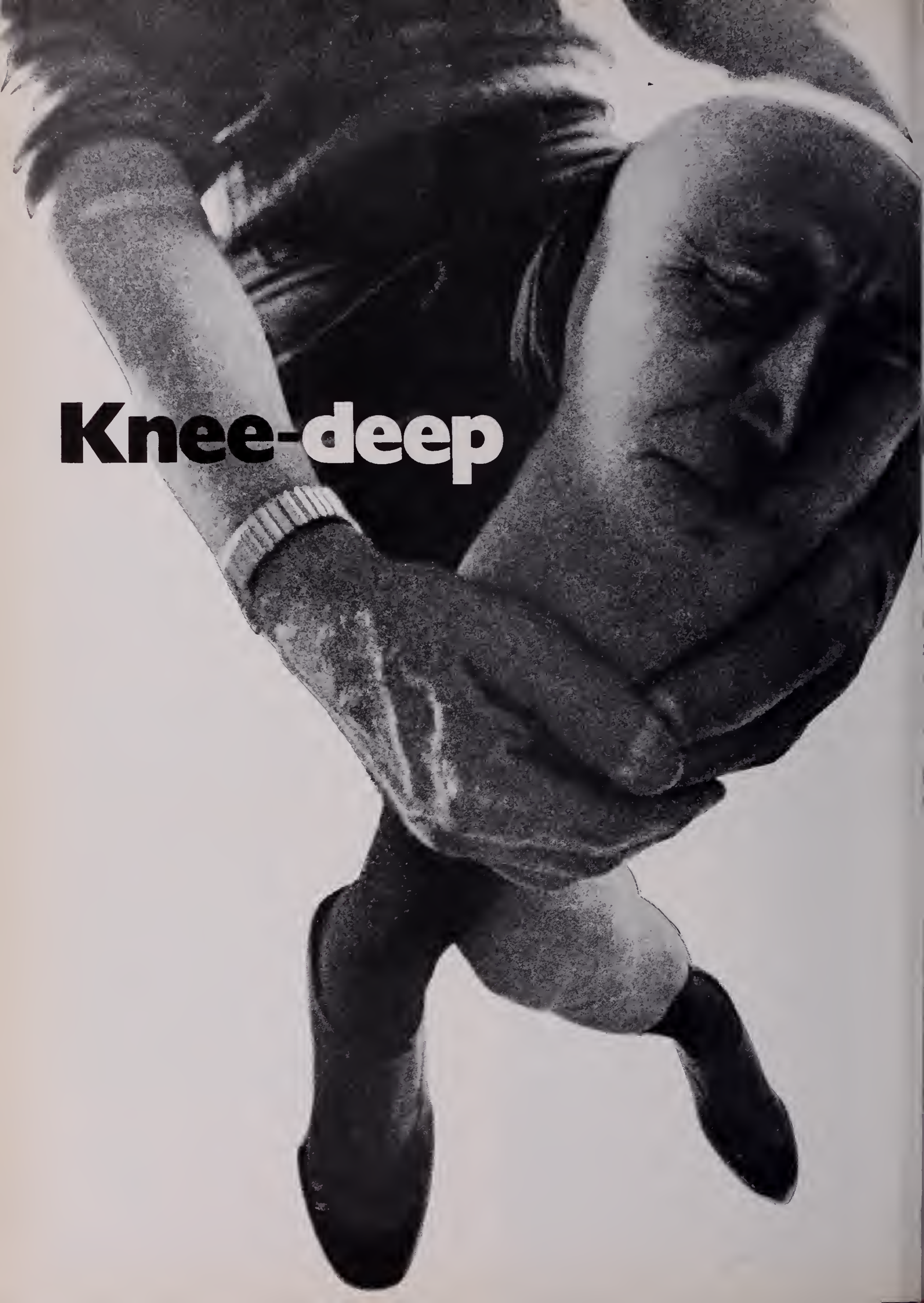
Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MSD **MERCK SHARP & DOHME** Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in ith Tandearil.

The trial period is brief: 1 week. ry one tablet q.i.d. at first. Tandearil sually starts working within 3 to 4 days. hen response occurs, as little as 1 or tablets daily may hold back pain and tiffness, and increase joint motion.

On the next page is a summary f adverse reactions, contraindications, arning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

ndearil, oxyphenbutazone:
r brief summary see next page.

Geigy

TA-6006

Tandearil®

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

in the treatment of
IMPOTENCE
Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . 50 mg.
Thiamine HCL . . . . 10 mg.
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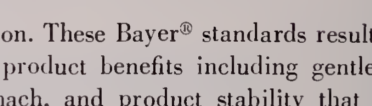

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Genetic Factors In Physical Growth and Development

BY JOHN C. GALL, JR., M.D.
DETROIT

INTRODUCTION

The observation that "like begets like" was probably one of the earliest scientific observations made by man. As applied to human growth and development, the influence of heredity is most striking in those conditions characterized by pathological growth, whether excessive (giantism) or inadequate (dwarfism).

PATHOLOGICAL GROWTH

DISORDERS DUE TO SINGLE GENES

Dwarfism. Obviously, many diseases can cause stunted growth, and a number of these are determined by single genes. The basic defect may be a disturbance of bone, a hormonal disorder, or an abnormality of cellular metabolism. An example, known from ancient times, is achondroplastic dwarfism. In this condition, which is due to an autosomal dominant gene, a disturbance of bone growth results in abnormally short bones of the extremities producing a very short individual with characteristic bodily proportions. Ancient Egyptian sculptures clearly portray the short arms and legs, the normal-size trunk and the relatively large head which is commonly somewhat hydrocephalic.[1] Although the condition does not result in sterility, relatively few achondroplastics produce offspring. Thus most cases are due to new mutations. There is usually no impairment of intelligence. A brilliant contemporary actor, who played the dwarf in the movie "Ship of Fools," is an achondroplastic.

The recognition of genetically determined syndromes associated with shortness of stature is important clinically, both in terms of adequate treatment and for purposes of genetic counseling. A very practical approach to the clinical evaluation of the short child has recently appeared in this Journal.[2] A useful (though not exhaustive) Compendium on Shortness of Stature, listing over 50 syndromes, many of them genetically determined, has recently been published.[3] Tables 1 - 3 list some of the genetically-determined conditions associated with impaired growth.

Giantism. Among the famous giants of history were the champion of the Philistines, Goliath, and the Roman Emperor Maximinus (172-238 A.D.), whose main claim to imperial power appears to have been his enormous stature, estimated by contemporaries at about eight feet. We are not certain of the diagnosis in either case. Perhaps the most common single-gene cause of giantism is Marfan's syndrome, sometimes called arachnodactyly because of the long spidery arms and legs present in most cases. The complete picture includes eye defects, in particular dislocated lenses, and cardiovascular abnormalities, most notably a tendency to develop aortic aneurysm. The basic defect, which is probably in the structural protein of connective tissue, may be the cause of overgrowth of the long bones.

It has been postulated that President Abraham Lincoln may have had Marfan's syndrome.[4] He was 6-4 and had a longer reach than any soldier in the Union Army. Many observers at the time noticed and commented on his long arms and legs, actually using the word "spidery" to describe them, and his official sculptor was impressed by the huge size and proportions of his hands. Just recently, several members of the Lincoln family have been definitely diagnosed as having Marfan's syndrome. This single dominant gene has apparently been transmitted through 8 or 9 generations.

CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities have very pronounced effects on growth and development.

Autosomal effects. Trisomy-21, Down's syndrome, or mongolism, is a classic example. Children with Down's syndrome, in addition to being mentally very slow, are quite small. At birth their size is close to normal, but within a year or two they have fallen significantly behind and tend to remain well below the tenth percentile throughout childhood.

THE AUTHOR

Doctor Gall is assistant professor, department of pediatrics and communicable diseases and research associate, department of medicine (Simpson Memorial Institute), University of Michigan Medical Center; and also medical geneticist, Plymouth State Home and Training School, Northville.

Figure 1 shows growth curves for a group of mongoloid children at Plymouth State Home in Northville.[5] It is interesting to note that those who are cared for at home do somewhat better, consistently, than those who were left in the institution at an early age.

Another autosomal abnormality that results in impaired growth is trisomy-18. However, since this condition is almost always lethal within the first year of life, slow growth is a relatively minor problem.

Sex Chromosomal Effects. A large number of sex chromosomal abnormalities are now known. If these are compared according to the presence or

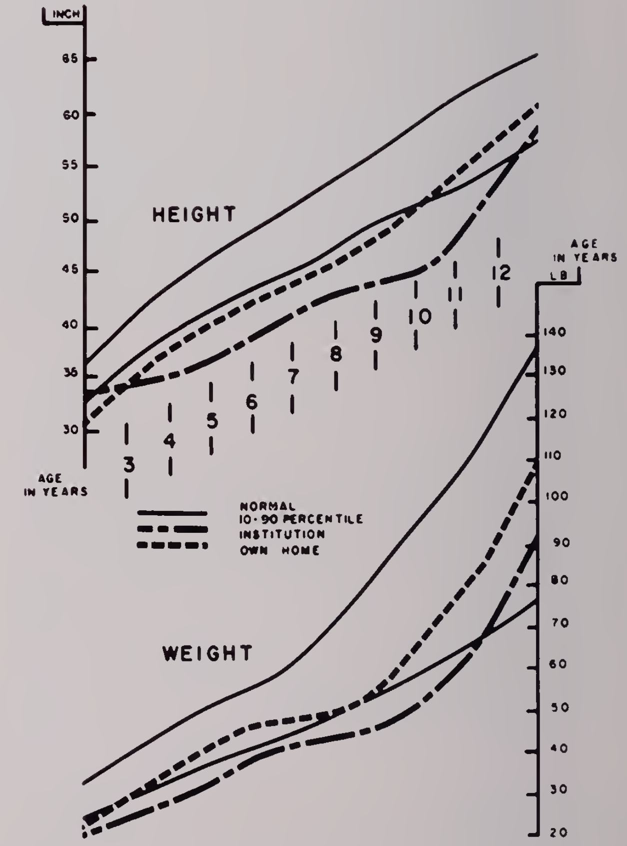

FIG. 1. Growth curves of 25 Mongoloids Raised at Home (dotted lines) and 40 Mongoloids Institutionalized in Infancy (dashed lines). The Solid lines represent the 10th and 90th percentiles for Normal Children.

TABLE I

Some single gene conditions associated with impaired growth.

SINGLE-GENE DEFECTS

AUTOSOMAL	SEX-LINKED
Recessive	
Isolated HGH deficiency Fanconi's syndrome (pancytopenia with multiple anomalies) Bloom's syndrome (telangiectatic erythema) Ataxia-telangiectasia Ellis-van Creveld syndrome (chondroectodermal dysplasia) Morquio's syndrome Hurler's syndrome (mucopolysaccharidosis) Cartilage-hair hypoplasia Hypophosphatasia Some forms of cretinism[12] Familial aldosterone deficiency[13] Cystic fibrosis	Menkes' syndrome (kinky-hair disease) Hunter form of mucopolysaccharidosis
Dominant	
Achondroplasia Cleidocranial dysostosis Osteogenesis imperfecta	Albright's osteodystrophy Hypophosphatemic rickets (pseudohypoparathyroidism)

Tables compiled mainly from Smith, D. W.[3]

TABLE II

Some chromosomal abnormalities associated with impaired growth.

CHROMOSOMAL ABNORMALITIES

AUTOSOMES	SEX CHROMOSOMES
Mongolism	Turner's syndrome (XO)
18-trisomy	XXXXY syndrome
Cri-du-chat syndrome	

Tables compiled mainly from Smith, D. W.[3]

TABLE III

Some conditions associated with impaired growth for which a genetic basis has not been definitely established.

GENETIC BASIS DOUBTFUL

Prader-Willi syndrome (mental retardation, obesity, cryptorchidism)
Smith-Lemli-Opitz syndrome (retardation, microcephaly, multiple minor anomalies)
DeLange syndrome (microcephaly, micromelia, synophrys)
Hallermann-Streiff syndrome (birdlike facies, atrophic skin, thin hair)
Seckel syndrome (bird-headed dwarfs)
Silver syndrome (skeletal asymmetry, cafe-au-lait spots)
Dubowitz syndrome (low-set ears, peculiar facies, and eczema)
Rubinstein-Taybi syndrome (broad thumbs and toes, mental retardation and unusual facies with beak-like nose)
Progeria (Hutchinson-Guilford Disease)
Leprechaunism

Tables compiled mainly from Smith, D. W.[3]

absence of one or more Y chromosomes, an interesting fact appears. The Y chromosome seems to confer added stature.[6] Children with Turner's syndrome (XO chromosome constitution) are abnormally short. The XYY male is often over six feet tall. For some unknown reason, the XYY male also seems to be rather aggressive, and several cases have been found by looking in the wards of the criminally insane for very tall individuals.[7]

NORMAL GROWTH

Polygenic Basis of Stature in Man. The genetic element in the determination of normal growth and development has been obvious down through the ages. Men have always recognized that small parents tend to have small children and tall parents tend to have tall children. However, this common observation was first put on a scientific basis earlier in this century by R. A. Fischer, who worked out the degrees of correlation in size between relatives that would be expected on the assumption of multifactorial Mendelian inheritance.[8] His calculations, which were based on a group of people with a very homogeneous background, tended to underestimate the importance of environmental factors such as adequate nutrition. Later studies[9] have suggested that environmental factors may account for a significant proportion of the variation in human stature. However, the hereditary factor is of preponderant importance, especially in advanced countries.

An additional complication in regard to human size is the existence of a pronounced maternal effect. Small mothers tend in general to have smaller babies regardless of the genetic factors involved. Parental influence on stature has been studied by Garn and others, who have compiled individualized tables of expected normal height and weight based on the sizes of the parents.[6] These provide a more accurate prediction of expected stature than standard height-weight tables.

Biochemical genetic factors. For some reason, there has been a lack of research on the subject of biochemical genetic factors in normal growth. One reason for this lack of research perhaps is the belief that growth is primarily determined by levels of human pituitary growth hormone (HGH), which, until recently, could not be assayed satisfactorily. The availability of assay methods for HGH opens up new fields for investigation of persons with abnormally great or small size, but it is still not known whether growth hormone levels are the primary determinants of stature within the normal range.

Isolated HGH deficiency. One especially interesting result of the availability of assay methods for human growth hormone has been in relation to a rare form of dwarfism known as sexual ateliotic dwarfism. In this condition, birth weight is normal but growth is very slow. Puberty does occur but may be delayed up to 25 years of age. Adult height of affected persons is well under 5 feet. There is no deficiency of TSH, FSH, or ACTH, but McKusick and his colleagues have shown that affected persons are almost completely deficient in human growth hormone.[10] The condition shows an autosomal recessive pattern of inheritance. In one of the families reported by McKusick, two affected parents produced an affected child whose birth weight was normal. This interesting experiment of nature demonstrates that intrauterine growth is apparently not under the primary control of either fetal or maternal growth hormone.

Bodily proportions — Obesity. Growth includes not only total body size and stature, but many additional elements for example, bodily proportions that distinguish tall, thin people from short, stocky ones; relative head size; and amount of body fat. Marfan's syndrome, as we have seen, is a good example of a genetic determinant of a long, lanky body type. Obesity is a more complex problem, since almost everyone has the capacity to become obese given the right combination of underexercise and overeating. However, certain genetically determined conditions are regularly associated with some types of obesity. An example is the Laurence-Moon-Biedle type of mental retardation. Children with mongolism are short and often have a roly-poly appearance.

Special Organs. The growth and shape of the eyes and the teeth are under very strong hereditary control. The story in relation to the eye is particularly interesting, as a recent study[11] suggests that eye measurements, such as the distance from cornea to retina, are almost entirely under genetic control and only minimally influenced by environment (with the exception of course, of destructive eye diseases and direct trauma). It is easy to see in a teleological sense why this is so, since a reasonable degree of visual acuity is absolutely essential for survival under primitive conditions; and this could not be maintained if the dimensions of the eye were subject to large fluctuations determined by environment.

Ethnic genetic factors. There are also racial differences in body size. Although these are to some extent due to the nutritional and other environmental circumstances under which different racial groups live, there is no doubt that genetic factors play a large part. The bodily proportions of the Watutsi, for example, many of whom are over seven feet tall, are genetically determined. The pygmies are genetically small. However, it must be stressed that the body chemistry of such groups has not been adequately studied to see to what extent differences in body size can be accounted for on the basis of known factors.

These, however, are questions for the human biologist rather than the clinical physician. The physician is primarily concerned with pathological growth, and in particular with the child who is too small. Such a child may have a disease that is preventing him from growing. It is up to the clinician to make the diagnosis and begin the proper treatment. An awareness of genetic factors and of inherited syndromes can be of assistance in this respect.

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Effects of Early Institutionalization On Growth and Development of Young Children with Down's Syndrome

ABSTRACT: Physical growth as well as motor and mental development of 40 children with Down's Syndrome who were institutionalized in infancy is compared to that of 25 similar children reared by their own parents.

All children are now ages 4-12 years old, have G-trisomy on karyotype analysis, had mongoloid features in infancy and similar birth weights. On the basis of this study and others it is apparent that parents of mongoloid infants should be told that most children with Down's Syndrome will become independent in such self-care areas as walking, talking, eating and toileting by the age of 6; that they will be accepted by day-care centers and special classes in public schools; and that they will attain higher levels of achievement, especially in speech, if they are not institutionalized at an early age.

However, the child with a physical defect which is incapacitating or incompatible with longevity might well be institutionalized if the parents so desire. Parents who elect to maintain their mongoloid child at home deserve their physician's support, encouragement and guidance.

The three co-authors are associated in the Research Department of the Plymouth State Home and the Training School at Northville.

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ROBERT GEAKE, Ph.D.
HOMER WEIR, M.D.
NORTHVILLE AND PLYMOUTH

By the time they are six years old, most children with Down's Syndrome are capable of walking independently, communicating effectively and caring for most of their personal needs. Communities throughout the nation have established day-care centers and special classes for such children in public schools. Nevertheless, many physicians continue to give parents a feeling of utter hopelessness when they produce a mongoloid child and then advise immediate institutionalization. That such a procedure produces deleterious effects on growth and development of young children has previously been reported.[1-4]

We relate in this article our own observations of 65 children, who are now 4-12 years old, with Down's Syndrome. Forty were institutionalized during infancy and have resided there ever since. Twenty-five are being reared in their own homes by their parents. Twenty children in this latter group are now in day-care centers or public schools.

According to Carter,[5] there are infants with most of the physical stigmata of Down's Syndrome who do not have typical G-trisomy and who in later years have normal intelligence. Early institutionalization of such infants would only lead to iatrogenic mental deficiency. Cytogenetic studies[6,7] are essential to establish the diagnosis of mongolism before institutional placement is considered. The children whose development is reported in this study all have G-trisomy.

METHODS

Among the 200 mongoloid children now in residence at Plymouth State Home and Training School, 40 were found who were admitted to a nursing home or institution during the first year of life and who are now 6-12 years old. These children have been weighed and measured at monthly intervals throughout life and developmental milestones were recorded in the form of progress notes as the children attained them. The 25 children being reared in their own homes have all been evaluated in the out-patient clinic at Plymouth State Home. From our own observations of these children during their visits and from their histories obtained from their parents, it was possible to derive similar measures on members of this group.

Eight measures of growth and development were considered: (1) height and (2) weight as recorded at two year intervals; ages at which patient first (3) walked independently, (4) talked effectively, (5) fed himself with a spoon and (6) became completely toilet trained. Our psychologists determined an intelligence quotient (IQ) using the revised form of the Stanford-Binet and the Wechsler Intelligence Scale for children, and a social quotient (SQ) using the Vineland Scale of Social Maturity for each of the 65 children. The IQ and SQ scores represent measures number 7 and 8.

A simple one-way analysis of variance test was used to determine whether there were any significant differences between the two groups on each of the eight measures. Chromosome studies indicate that all patients have G-trisomy. No patient with normal karyotypes, mosaicism or translocation were considered in this study.

RESULTS

The results are summarized graphically in charts 1 and 2, and the mean values are given in tables I, II and III. The mean IQ and SQ scores for 40 institutionalized children with Down's Syndrome were 17.6 and 29.5, resp., compared to 35.6 and 54.2 for similar children reared at home. These

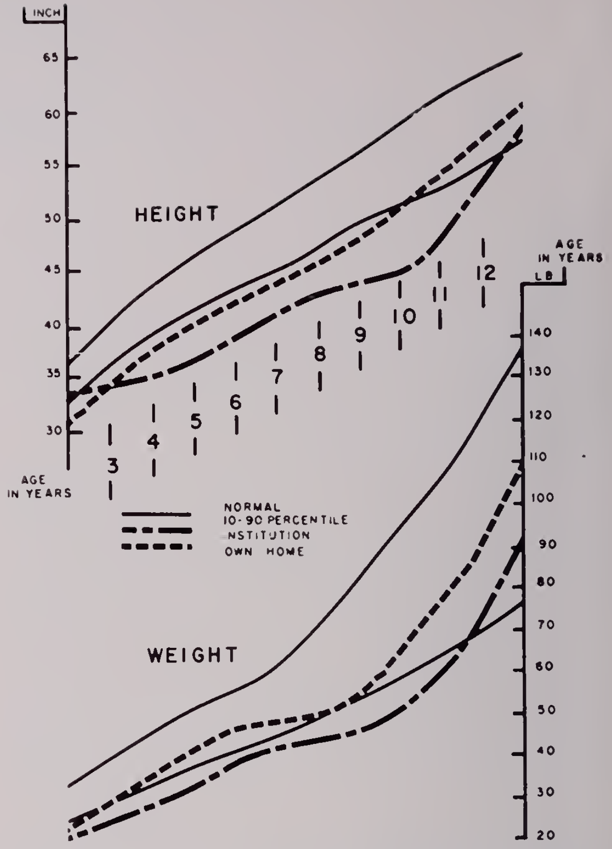

CHART II: Physical growth of institutionalized and non-institutionalized groups of children with Down's Syndrome compared to normal children.

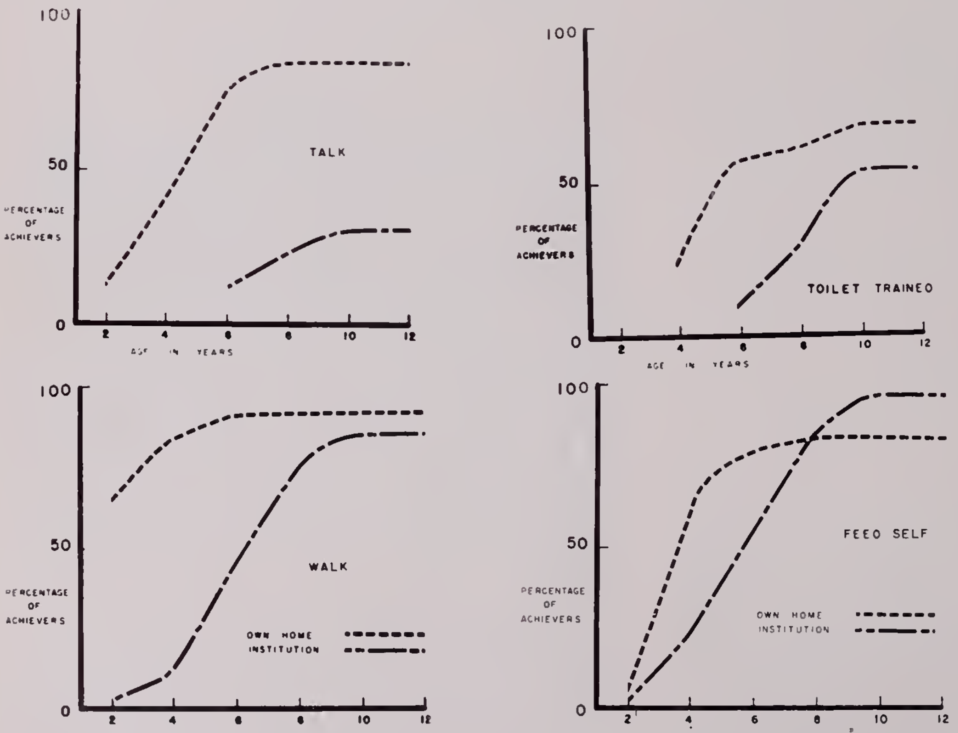

CHART I: Ages at which institutionalized and non-institutionalized children with Down's Syndrome attained four important developmental milestones.

scores reflect the effects of intellectual stimulation, training and experience as well as innate capabilities to learn. The institutionalized children learned to walk independently and feed themselves at a mean age of just over 6 years whereas their fellows reared at home accomplished these at mean ages of 3 for walking and 4 for self feeding. Twenty-one of 40 institutionalized children are toilet trained and they accomplished this at 8 years; sixteen of 25 children living at home completed this training at a mean age of 5 years. Only 10 of 40 institutionalized children are talking effectively and they did not accomplish this until a mean age of 7.8 years. Twenty-one of the 25 children living at home are talking effectively and this was accomplished at a mean age of 4 years. All of these differences are significant at the .01 level.

In general, heights and weights of patients in both groups remain at about the third percentile until age 8 years; they then increase to reach the 25th percentile at age 12 (graph 2). Analysis of variance reveals no significant differences in either height or weight between the two groups. Apparently institutionalization has not produced an effect on physical growth of the 40 children considered in this study. Up to and including age 8 years, our children are similar to those reported by Thelander and Pryor;[8] however, our values for ages 10 and 12 are higher than theirs. Only

TABLE I

Mean Developmental Measures for Institutionalized Mongoloids And Those Living in Their Own Homes

	Institutionalized	Home	Difference *
IQ	17.6	35.6	18.0
SQ	29.5	54.2	24.7
Age Walked (yrs.)	6.31	2.64	3.67
Age Fed Self (yrs.)	6.13	4.26	1.87
Age Toilet Trained (yrs.)	8.57	5.00	3.57
Age Talked (yrs.)	7.80	4.05	3.75

* All differences significant beyond the .01 level

TABLE II

Mean Growth Measures for Institutionalized Mongoloids And Those Living in Their Own Homes

Height	Institutionalized	Home	Difference *
2 years	29.4 inches	29.7	0.3
4 years	34.3	37	2.7
6 years	37.6	41.5	3.9
8 years	42.8	45	2.2
10 years	44.4	51.5	7.1
12 years	54	57.8	3.8
Weight			
2 years	19.1 pounds	21	1.9
4 years	26	34	8.0
6 years	32.7	45.3	12.6
8 years	41.4	45.7	4.3
10 years	48.9	64.0	15.1
12 years	72.7	90.8	18.1

* Differences are not significant

TABLE III

Mean Values of Other Variables for Institutionalized Mongoloids And Those Living in Their Own Homes

	Institutionalized (N = 40)	Home (N = 25)	Differences *
Year Born	1958	1959	1 year
Birth Weight	6.78 lbs.	6.38 lbs.	0.4 lbs.
Ratio Males: Females	18:22	17:8	
Other defects	10 (25%)	4 (16%)	(9%)

* Differences are not significant

eight of the patients considered in our study have attained the age of 12 years while 16 have reached the age of 10. While this small number of cases allows comparison of the institutionalized to the non-institutionalized groups of patients at these ages, the number is insufficient to conclude that the height and weight of mongoloid children approaches normal values at age 12 years as suggested by the graph.

Other variables, including year of birth, birth weight, sex and presence or absence of other defects, were considered to determine whether the patients constituting the two groups were similar. The available data indicates that they were (table III).

DISCUSSION

When parents receive the shattering news that their offspring is afflicted with Down's Syndrome, one of their first questions is "Should we take the child home with us?" In the past, physicians have often advised the parents to place the child immediately in a nursing home or institution and try to forget it, and even to tell the other children and relatives that the child died! Such a procedure is detremental to the child and parents alike. We have never encountered parents who were able to forget. Those parents who did follow this procedure developed strong guilt feelings which were often more harmful to the marriage and other children than the presence of the afflicted child in the home would have been.

We realize that some families would not survive with a mongoloid child in the home and endorse the philosophy of Birch and Belmont[9] that antiplacement rigidity is no sounder than proplacement stereotype as a basis for the early management of mentally defective children. We feel that the following procedure is sound whenever parents and their physician are considering the placement of a mongoloid infant in an institution for the mentally retarded.

1) Cytogenetic studies are done to substantiate the diagnosis. Children with normal karyotypes, mosaicism and even translocation should not be institutionalized, on the basis of mongoloid features, unless at age four or five years they are found to be severely retarded.

2) The parents are told that (a) most children with Down's Syndrome will be able to walk, talk, feed and dress themselves and become toilet trained by the time they are six years old and that day-care centers and special classes in public schools are accepting such children. As small children, mongoloids present the same problems of care that normal children do. While it is true that children with Down's Syndrome are susceptible to respiratory and skin infections, such infections respond well to medical treatment. Unless the infant has a symptomatic heart defect or other incapacitating congenital anomaly, his care will be very similar to that of normal babies. (b) If the afflicted child is raised in his own home his motor and mental development will be closer to normal than if he were raised in an institution. The average IQ of school-aged children with Down's Syndrome who are raised in their own homes is 40 compared to 20 in institutionalized cases. Thus, for the good of the afflicted child, parents are urged to maintain the infant at home at least until he is 6 or 7 years old. (c) Like all children, those afflicted with Down's Syndrome need emotional support and intellectual stimulation during their formative years. Children with Down's Syndrome are most responsive to love and affection; they are demonstrative and capable of giving their parents a great deal of love and satisfaction.

3) If the child is born out of wedlock or the parents express no interest in further involvement with the child, a suitable foster home placement may be possible.

4) Patients are accepted as guests to our institution for a short period when their presence in their own homes would be devastating to the family. This gives the parents a chance to work through their problems with whatever help we can offer away from the immediate stress caused by the presence of the afflicted child in the home.

5) We may advise a period of institutionalization for those children who have other congenital defects which are not immediately correctable and which make care unusually difficult for the parents. During this period the child will be evaluated by our consultants to determine the feasability of correcting the deformities so that the child may return home.

6) If the child should have an uncorrectable defect which is also incompatible with longevity, we will advise institutionalization if the parents are uneasy about caring for the child.

In spite of our attempts to support in any way we can those parents who are willing to try to maintain their mongoloid child at home, we still find it necessary to admit some young children with Down's Syndrome to the institution. We are now trying to impress on our ward personnel the importance of talking to the children and of using their own ingenuities and natural mothering instincts so as to encourage the early motor and mental development of our patients. Because of more intensive programming, our patients are developing at a better rate than did patients five or six years ago; but they are still not doing as well as their fellows who were fortunate enough to be reared in their own homes.

SUMMARY AND CONCLUSIONS

1) Twenty-five children with Down's Syndrome who are now ages 4-12 years and reared in their own homes by their parents, learned to walk and talk at a mean age of 4 years; they were toilet trained and able to feed themselves at 5 years. Twenty of them are now enrolled in special classes in public schools or day-care centers. Forty similar children who have been institutionalized since infancy learned to walk and feed themselves at a mean age of six years and talk and care for their own toilet needs at 8 years; only 10 of the 40 institutionalized children are able to talk effectively, presumably because of lack of speech stimulation. Statistical analyses indicate that the differences between these two groups are significant at the .01 level of confidence on all measures.

2) Twenty-five children with Down's Syndrome who were reared by their parents now have a mean IQ of 36 and SQ of 54; the 40 children institutionalized in infancy have a mean IQ of 18 and SQ of 29. Statistical analyses utilizing analysis of variance, indicates that these differences are significant at the .001 level of confidence.

3) Physical growth as indicated by height and weight at certain ages follows the third percentile until age 10 when it approaches the 10th percentile and then proceeds to the 25th percentile by age 12. Differences of physical growth between institutionalized and noninstitutionalized children are not statistically significant.

4) Physical stigmata of Down's Syndrome can occur in individuals with normal intelligence. In as much as early institutionalization may produce irrevocable damage to such individuals, chromosome studies are essential in order to substantiate the diagnosis before any long-term plans are made.

5) The young child with Down's Syndrome will not present unusual problems of care to his parents unless he has certain congenital defects. He will respond appropriately to love, training and intellectual stimulation. He will be ambulatory, verbal and independent in self care activities by the age of six years. There are school and day-care programs in most communities which will accept him.

6) The child with an incapacitating physical defect or a defect which is incompatible with longevity may be institutionalized. If the defect is corrected and the child regains his capacity of functioning, he should return to his own home.

7) Parents are more willing to raise their mongoloid child if they have the support, advice, and skill of their family physician to guide and encourage them.

8) Physicians and other professionals in institutions must set an example and thereby impress upon the minds of ward personnel, the importance of talking to the residents as the best way of stimulating speech development. Failure to do this allows the children to develop into beings who communicate only by grunts, crys, gibberish and gestures. Children in institutions should be encouraged to walk by themselves and care for their personal needs as soon as they are able to learn.

THE AUTHORS are grateful to members of the departments of medicine, social service, psychology and nursing at Plymouth State Home and Training School who have recorded a wealth of information about our patients; to Miss Judith Stack, M.T., A.S.C.P., James Alston, Noble Kheder, Mrs. Barbro Hicks and Ronald Wilson, B.F.A., P.P.A. and R.J. Giesige, Jr. for technical assistance; to Mrs. Barbara Gariepy of Wayne State University Computer Center; and to Miss Kathy Hoye who typed the manuscript.

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Editorial Note:

The problem of advising the family with a child with Down's Syndrome is a very difficult one. It is fraught with many perils including that of the physician's own emotional make-up. The author certainly gives us food for thought.

A STUDY OF ITS EFFECT ON 50 FAMILIES

Severe Asthma in Children

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While many advances have been made in knowledge of the factors causing bronchial asthma as well as in the various allergic, pharmacologic and emotional treatment modalities available, there still remains a "hard core" of asthmatic children who experience severe, chronic, intractable asthma which is resistant to present forms of therapy.[1]

Considerable thought has been given to the reasons for this intractability in certain children's asthma. Various members of the health profession have shared a common concern regarding the treatment of these asthmatic children.

The allergist or pediatrician seeing the child in the office, clinic, home or hospital is frequently impressed with the resistance to treatment which characterize this patient population. Resistance in this sense is construed as any response to a therapeutic regime which does not yield satisfactory improvement, i.e., little or no amelioration of the asthma. Thus, a patient's lack of response to one or another antibiotic and pharmacologic regime (with or without steroid therapy), dietary schedule, hyposensitization, avoidance program and hospitalization constitute one pattern of resistance. Similarly, a parent's inability to carry out a prescribed program adequately constitutes another form of resistance.

Quite commonly it is observed that there appears to be an interdigitation of the forms of resistance. The psychological and emotional interactions between children and parents, the emotional climate in the home and community, and the degree of stress (e.g., separation experiences, periodic changes in environment, school failure, economic instability, etc.) all may conduce to the development of a situation within which the most effective medical management risks failure.

In order to begin to explore the dimensions of the problem and develop some guidelines for continuing work, an exploratory project was undertaken by members of the Allergy staff in collaboration with the Department of Social Work, University of Michigan Hospital. The charge given to the investigators was as follows: To interview and collect data on a sample of families whose family physician considered their child to have severe chronic asthma, the sample to be drawn from various areas of the state on referral by physicians in private practice. The specific objectives were twofold: (1) to further document the existence of a significant number of children with severe, chronic asthma; (2) to describe the impact of such an illness on the family constellation and its functioning.

Practicing allergists and pediatricians throughout the State of Michigan were initially contacted by letter informing them of our proposed investigation and inviting their participation, requesting (1) that they provide the names of families in their practice having an asthmatic child who, in their judgement, had severe asthma and was resistant to treatment under present circumstances or manageable only with chronic steroid administration and (2) inform the families of their (the doctor's) participation in this project and encouraging the families' cooperation. In this fashion, 23 physicians identified 62 such families, and the first 50 were interviewed.

Form letters were then sent to the families requesting their assistance in this project, referring to the family physician by name as the source by which they became known to us. Simultaneously, the referrals were organized by geographical distribution and contacts made by the Department

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Doctor McLean is professor of internal medicine at the University of Michigan Medical Center; Mr. Schrager is director of the department of social work, University Hospital, and assistant professor of the U-M School of Social Work; Mr. Stoeffler is assistant director, department of social work, University Hospital, and clinical assistant professor, department of psychiatry, U-M Medical Center. John M. Sheldon, M.D., now deceased, assisted in the early preparation of this paper while director of the U-M Medical Center Section of Allergy. The study was supported by a grant from the Michigan Tuberculosis and Respiratory Disease Association.

of Social Work with professional colleagues in social agencies and child guidance clinics in proximity to the family residence. In this manner a team of interviewers was recruited, all having appropriate professional preparation for undertaking this task.* A mimeographed questionnaire was developed by the Department of Social Work, University of Michigan Hospital, and the Allergy staff around which could be conducted a structured interview, and these, with full instructions regarding their use in obtaining additional material which appeared pertinent during the interview, were sent to all of the interviewers.

By telephone contact, each interviewer then introduced himself to the family, referring to the family physician and the University as his sponsor and requesting an appointment to conduct the interview. All interviews were carried out in the family residence, with both parents in attendance in the majority of cases and often with the children in and out of the setting.

Accompanying each questionnaire was a rating sheet to be completed by the interviewer concerning the effect of the child's asthma on the family. This consisted of six items: effect on family economy; effect on other siblings; effect on parents' ability to cope with the child and his illness; effect on the total household; effect on patient's schooling; and effect on patient's relationship with his peers. These were graded on four degrees of severity: no effect, some effect, severe and very severe.

Interviews and rating sheets were mailed to the University Hospital whereupon three additional raters (the senior authors), employing the same measures, independently rated each case. In making a decision, each rater reviewed the 15-page questionnaire in its entirety and then again for the specific factors listed above. An assessment was made in this context, and scores were then assigned to each item on the rating sheet: no effect equaled 0; some effect equaled 2; severe equaled 3; and very severe equaled 4.

DESCRIPTION OF THE SAMPLE STUDIED

The 50 children referred by physicians were divided into age groups: Group 1 (3-6 years), N=12; Group 2 (7-10 years), N=21; Group 3 (11-14 years), N=15; Group 4 (over 14 years), N=2. (Table I).

Thirty-one children in the sample were males, 19 were females. Thirty percent of the referred group were first children. (Table II).

TABLE I

AGE OF SAMPLE

AGE (Years)	TOTAL
3 - 6	12
7 - 10	21
11 - 14	15
over	2
	50

TABLE II

ORDINAL POSITION

Ordinal Position	TOTAL
1	15
2	13
3	10
4	7
5	2
6	0
over	3
	50

Viewed in terms of racial distribution, the group was representative of the population of the state as a whole — slightly less than 10 per cent of the sample being Negro. It should be pointed out, however, that this figure would vary widely in different sections of the state, since the Negro population is mainly concentrated in the larger urban centers.

Each referral was rated in terms of the social class position of the father. In assigning a social class position to each family, the indicators used were employment and education of the breadwinner. The basis for this choice is found in the work of Hollingshead and Redlich[2] & of Harrison, et. al.[3], in their work on social class and mental illness in children. Five social classes were identified: Class 1 (unskilled or unemployed), N=12; Class 2 (skilled labor), N=13; Class 3 (lower white collar), N=14; Class 4 (upper white collar), N=4; and Class 5 (professional or executive), N=7. (Table III).

Of the 50 children in the group, more than 60 per cent came from families with three or more children. (Table IV). Six of these families were single parent families, due either to divorce, separation, or death of one of the parents.

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* Although there was some predictable unevenness in the skill of the interviewers, all eight were professionally trained at the Master of Social Work level and all were members of the Academy of Certified Social Workers.

TABLE III

SOCIAL CLASS

Social Class *	TOTAL
1	12
2	13
3	14
4	4
5	7
	50

* See text for description

TABLE IV

NUMBER OF CHILDREN IN FAMILY

Number	TOTAL
1	6
2	12
3	9
4	8
5	8
6	3
over	4
	50

Thirty-five of the children came from families in which there was a clear-cut history of allergic disease, 20 of these families having bronchial asthma as the manifestation. (Table V). Sixteen of the asthmatic children had, or had had eczema, and eight of these children also experienced hay fever. In 24 of these children, food elimination diets were being carried out for present or suspected food sensitivity, and this was questioned in six additional children.

TABLE V

MEDICAL ASPECTS

Significant family history of allergy	35
Significant family history of asthma	20
Associated atopic eczema	16
Associated hay fever	8
Food allergy found or suspected	24
Infections appeared important	32
Steroid therapy ("Burst" or continuous)	25

TABLE VI

COURSE OF ASTHMA

ONSET	Birth - 13 years
Mean	2.8 years
Median	1.5 years
DURATION	1.5 - 16 years
Mean	6.1 years
Median	6 years
SEVERITY	
Moderate to severe	10 patients
Persistently severe from onset	15 patients
Severe to moderately sever (steroids)	19 patients
Variable severity	6 patients

Infection seemed to be a very important factor in triggering or perpetuating the asthma in 32 children, 18 of which seemed to have a "cold" or infection much of the time and had received multiple courses or continuous antibiotics. All of the children had received or were receiving some type of hyposensitization therapy.

The onset of asthma varied from birth to 13 years of age, the mean age of onset being 2.8 years and the median being 1.5 years. The duration of asthma ranged from one and one-half years to sixteen years, the mean being 6.1 years duration and the median being 6 years. (Table VI).

Although all the children in this study were considered to have severe chronic asthma by their family physician or pediatrician, different degrees of chronicity and severity were evident at the time of the visit by the research interviewer. All of the children were or had been severe chronic asthmatics. At least 19 of the children were experiencing only moderately severe asthma at the present time due either to steroid therapy or partially effective medical management. Twenty-five children were on either "burst" or continuous steroid therapy. Ten of the children had experienced only moderately severe asthma at the onset and then progressed to severe and chronic symptoms while 15 had been severely asthmatic from the beginning. The remaining six children were characterized by asthma of variable severity.

RESULTS

EFFECT ON FAMILY ECONOMY

Within the limits of this study, we have tried to evaluate the economic impact of severe asthma in a child upon the family organization. Table VII provides some evidence of this effect. In our sample, the costs of medications ranged from $3.00 per month to $166.00, with 19 families paying more than $31.00 per month.* This study indicates that the higher costs seem to be borne by persons who are in the higher income bracket ($8,000.00 plus).** (Figure 1). Given the fact

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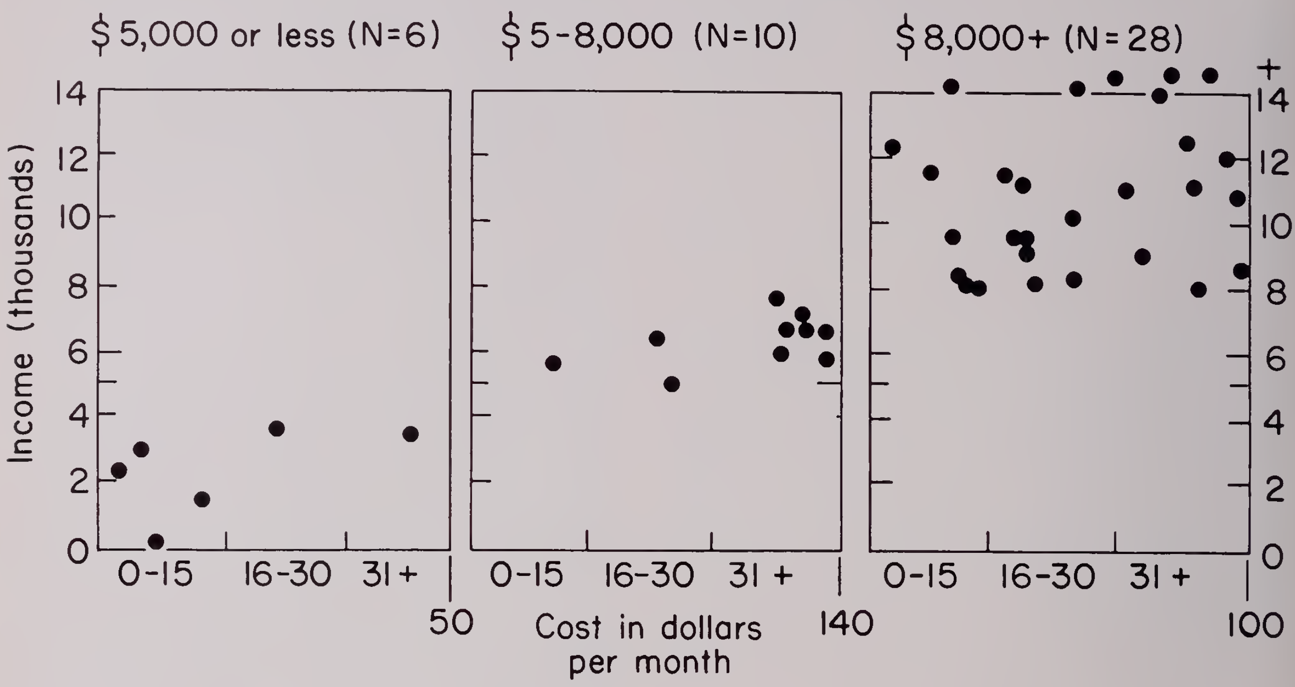
* The questionnaire used by the interviewers did not include a question regarding doctors' fees specifically but only the cost of medications; in some cases this included the cost of hyposensitization and epinephrine injections. Professional fees must be added to the amounts indicated above in order to arrive at the true picture of total medical management.

**Figure I contains 44 families whose income was stated. Table VII lists a total of 47 families whose medication expenses were known.

Figure I

EXPENDITURE FOR MEDICATIONS VS. FAMILY INCOME



that all children (with one exception) were seen by private physicians and all were referred on the basis of criteria which were applied equally, it is difficult to understand why higher costs were distributed in this fashion. Further analysis showed, however, that higher medication costs also could be related to the severity of the asthma. Reviewing the income ranges (as grouped in Figure I) vs. asthma severity, it can be seen from Table VIII that 50 per cent of the children from families with income of less than $5,000 per year were severe asthmatics, 70 per cent of the children in families with income from $5,000 - $8,000 were severe and 53 per cent of the children in families with income above $8,000 were severe asthmatics. Thus, it would appear that higher expenditures for medications by those families with a greater income may be partly but not entirely dependent on the severity of the asthma, but also related to income.

In 12 families both parents were employed. Significantly, of these 12 families, four earned less than $7,500 as the combined income of both parents, and their expenditure for medications for the asthmatic child ranged from $33 to $137 per month ($396 to $1,644 per year). Thus, unusually high expenditures struck that part of the sample least able to pay for service, and one could assume that the effect of this drain on the resources of these families must have had deleterious effects on the family as a whole.

TABLE VII

MEDICATION COST

$ 3 - $ 15 per month	13
$ 16 - $ 30 per month	14
$ 31 - $ 40 per month	6
$ 41 - $ 50 per month	4
$ 51 - $ 60 per month	1
$ 61 - $ 70 per month	2
$ 71 - $ 80 per month	1
$ 91 - $100 per month	4
$131 - $140 per month	1
$160 per month	1

TABLE VIII

ASTHMA SEVERITY VS. INCOME

Asthma Severity	Income less than $5000 per year	$5000-$8000	$8000+
Severe	3	7	15
Moderately Severe	3	3	13

One family paid a minimum of $25 a week for medical expenses and had gone bankrupt twice. Thirty-one of the families had purchased some type of special equipment for the home such as a dehumidifier, air filter, air conditioner or croup tent for the child's bedroom. Thirteen of the 31 had purchased two or more pieces of such special equipment. Most families, with the exception of five, did not suffer any significant economic hardship because of the hospitalization of the child. This was usually covered by insurance or by monies available through public sources. The stay in the hospital, although relatively short (generally under two weeks), simply represents a suppression of the acute crisis.

Although this study was based upon a small sample (and a rather selective one since all subjects but one were referred by private physicians), one can suggest that the evidence indicates that the effect of asthma in children upon the economic well-being of the family is appreciable.

EFFECT ON OTHER SIBLINGS

Review of the questionnaires revealed that children in some families resented the extra personal attention the asthmatic sibling required. This was found to be true in 16 of the 44 families with more than one child (36 per cent). There were 25 families in which this was not a problem and three families in which this was undetermined. The other siblings protested also the manipulative way in which the ill child demanded the attention of the parents or other members of the family. This was particularly true when the child was acutely ill and needed special care and attention from the parents, especially the mother. In three families siblings felt guilty about the asthmatic's condition in that they may have been "responsible" (through active play or some other kind of interaction) for the onset of an acute attack. It should be noted, however, that this information was not uniformly inquired about in the course of the interview but was offered spontaneously by the informants.

The parents of 17 families reported that their child-patient became irritable and crochety when suffering from the effects of an asthma attack. Whining, complaining, and aggressive behavior directed at others, including siblings, made them quite unpopular and to be avoided when symptomatic. The ensuing social isolation of the asthmatic child in turn may produce additional anger and guilt on the part of other members of the family social system.

EFFECT ON PARENTS

The child's asthma presented rather severe problems for some parents in essentially two ways: handling the physical and concrete realities of the disease; and handling the behavior of the child within this context. In 14 families at least one of the parents felt frustrated and bewildered. Twelve families reported work-time lost because of the child's asthma, and in four families this was a significant amount (1½ days a week in one family, "much work time lost" as contrasted to "little" in others). Thirty-seven families reported loss of sleep because of the child's asthma with one-half of these (18) reporting on the average of at least one hour per night lost. They realized that the care they gave to the ill child often took their attention from other members of the family who felt "short changed."

Parents become concerned about the child's activity at home and at school and how this may affect his health. Most parents would consciously wish that the child could run and play like other children but at the same time do not want the child to become overtired or involved in activities which might precipitate an asthmatic attack. They feel that the price they and the child might pay for taking undue risks is too great, and they would rather "play it safe."

Many parents (30 families) have a difficult time in coping with the child and his illness because they fear that their normal, spontaneous attempts at discipline might be contraindicated. Frequently this results in a "double standard" of discipline; one for the asthmatic child and another for the well child. They fear that punishment and restriction will upset the child and cause an attack of asthma; and so they refrain from employing their parental prerogatives. The parents feel frustrated because they feel that the child has manipulated them and guilty because they are not being consistent with other children in the family.

EFFECT ON TOTAL HOUSEHOLD

The existence of chronic asthma may have its disabling effects on the entire household because the disease and its consequences, rather than the needs of all the individual family members, may dictate the adjustment of the family unit in many areas of living and over an indefinite period of time. In half of these families activities were frequently curtailed or abandoned because the asthmatic child could not participate, and thus the whole family suffered from the restriction. For example, some families would not go where it might be dusty, or where a heavy pollen or dander exposure was likely. Wet, damp weather is often an inhibitor of activities whether they be routine, recreational or pertaining to school. Parents are unwilling to leave at home a child who is acutely ill and reluctant to hire a baby sitter to stay with the child for fear that a crisis might arise during their absence. Hence, many families are bound pretty close to home when they might ordinarily choose to do otherwise. For a few families, repeated hospitalization of the asthmatic child draws the parents (especially the mother) physically and psychologically from the home and the other siblings.

EFFECT ON PATIENT'S SCHOOLING

Eighteen children missed more than 20 days of school per year. Some children were good or excellent students, and being absent from school for repeated or extended periods of time did not seem to have an adverse effect on their academic performance unless of course those students who were described as "average" could have become "good" students if they had missed less school. Table IX shows that the majority of "poor" students actually missed less time than the "good" and "average" students. Other reports have shown that the intelligence of asthmatic children is representative of the general population. The number of students in the "good," "average" and "poor" performance categories in Table VIII is in accord with this observation. Twenty-five of the children had to restrict their school activities because of asthma. For example, they had to stay inside the school on damp or wet days when others could be outside. Gym and playground activities were not allowed or were limited.

TABLE IX

SCHOOL PERFORMANCE VS. SCHOOL ABSENCE

SCHOOL DAYS MISSED	TOTAL	STUDENT PERFORMANCE "Good"	"Ave."	"Poor"
0 - 10 days	13	5	5	3
11 - 20 days	7	4	2	1
21 - 40 days	11	4	5	2
41 - 60 days	5	2	3	0
61 +	2	1	1	0
Unknown	3	0	1	2
Not applicable (Children not school age)	9			
TOTAL		16	17	8

EFFECT ON PATIENT'S RELATIONSHIP WITH PEERS

As a group, these children were not particularly undesirable as companions, nor did they have characteristics which were offensive to their peers. At least none was discernible from this study, except for irritability and complaining when having asthma.

DISCUSSION

It was observed that the child with severe asthma had varying effects on the family. Although many of the families found that the economic burden was very severe, the cost of hospitalization was lessened considerably by insurance programs for some of the families and public sources (Crippled Children's Commission and the State Department of Social Services) of support for others. It was observed, however, that 19 of the families paid more than $31 per month for medications. While higher income families paid more for medications, this cost did not necessarily reflect the severity of the asthma, since all income groups had children with severe asthma. Too, these families were better able to bear the cost of the medical regime recommended.

In the lower income groups, this financial burden certainly could have contributed to the "worry" over the chronic asthma. Regarding the 12 families with both parents employed, it is uncertain whether or not 24% is an unusually high figure for dual employment as contrasted to the total working population, but it would appear that the asthma cost could be a contributing factor to the necessity for dual employment in the families in this study.

While it has been shown previously that social classes 1 and 3 (as outlined above) are economically most vulnerable in our social system,[3] it should be noted that there were seven children with intractable asthma from professional and executive families in this study. While chronic asthma did not seem to have any relationship to social class, the economic effects were more profoundly felt by families from the lower socioeconomic groups.

Besides 36 per cent of the families with more than one child noting resentment by the other siblings over the extra attention given to the asthmatic child, problems in handling the behavior of the asthmatic child and his siblings were noted in 30 of the families (60 per cent). On the other hand the data indicate that the majority of families were apparently able to handle the asthmatic child and his brothers and sisters fairly adequately, and that these asthmatic children were able to keep up with the "average" school performance.

The impression is gained from reviewing the questionnaires that families felt considerable hardship at the time of onset of the asthma, and during the time when the asthma was being brought under partial control. When control was not achieved or was intermittent at best, stress was felt more continuously.

After a period of "reprieve" from acute symptoms and the need for intensive care, the family again felt the original strain at the onset of each exacerbation of asthma. Although the family may have been greatly inconvenienced when they lost sleep, had to pay a great deal for medicine and had to restrict the child from school and activities and even hospitalize him, after the symptoms subside they seemed able to return to a somewhat more normal routine. The continuation of subacute attacks, however, may have influenced the family's ability to adapt and manage the illness and the other children.

The total family may have experienced possible disruption in other ways. Feelings of uncertainty by the parents, both as to the medicines used in treatment and their own inability to help the sick child, reinforced the feeling of helplessness. Added to these factors are the resultant curtailment of the child's and family's activities and the problems of maintaining both love and discipline for all the children within the family.

The effects of these influences became unmanageable in some cases and become further complicated by the emergence of problems in siblings which might not have been precipitated if the total family situation were more "normal."

"Intractability" or "resistance" to treatment may be related at times to some of these factors. Programs for the management of such asthmatic children should take into account the total family. Therapeutic counseling for the family constellation has been recommended by others in the treatment of the institutionalized asthmatic child,[4] and our report has indicated that social factors appear relevant in many of these families of severely asthmatic children who were not institutionalized. On the positive side it should be noted that many of these families were apparently carrying on very well despite the potentially disrupting influence of the severely asthmatic child.

SUMMARY

The families of 50 children with severe, chronic asthma have been surveyed by social workers. The following parameters were specifically investigated: effect on family's economy; effect on other siblings; effect on parents' ability to cope with the child and his illness; effect on the total household; effect on patient's schooling; and effect on patient's relationship with his peers.

Thirty-three of the families had a cost of $15 per month for medication expenses with 19 families paying more than $31.00 per month. Thirty-six percent of the families with other children noted sibling resentment toward the asthmatic child. Fourteen of the families felt bewilderment and frustration due to the chronic illness, and 30 families experienced difficulty in coping with the asthmatic child. Family activities and school activities were influenced in half of the cases. In addition, work-time and sleep-time loss were documented. In some families among this selected group of chronic asthmatic children, a total treatment program would appear to necessitate social and psychological, as well as medical aid.

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The Treatment of a Psychiatric Emergency In a University Hospital Setting

ABSTRACT — One of the responsibilities of a University Hospital is the evaluation and appropriate management of psychiatric emergencies. A conceptual model of an "ideal" emergency program is presented, and a structural format for dealing with emergencies is outlined. The structure includes: a telephone service, a walk-in service, a crisis intervention clinic, a consultation service, and a flexible use of inpatient beds. The implications of the service-training-research triumvirate is discussed here in the context of the residency program.

BY PHILIP M. MARGOLIS, M.D.
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BOTH OF ANN ARBOR

INTRODUCTION

A 17-year-old boy was seen recently in the Emergency Room of a local hospital because he took an overdose of tranquilizers. A psychiatrist did not see him. He was given sedatives, and sent home with his brother who left him at the home of friends. It was suggested that he see a psychiatrist, though this information was communicated only to the boy.

Two days later, I received calls from the school nurse and the school principal who were concerned about his alternating violence and somnolence. He was brought into the University Hospital Emergency Room, was seen by a psychiatric resident who chose not to admit him. The Neurology resident was furious, but admitted the boy to the Neurology service. He was finally transferred to the psychiatric unit 24 hours later.

A University Medical Center has certain responsibilities — both to itself and to the extra-mural community of which it is a vital part. Many University Medical Centers are ambivalent about providing psychiatric emergency services, and departments of psychiatry are no exception. The decision — to provide or not to provide — rests upon many factors, not the least of which is the Department of Psychiatry's conception of its function. A University (General) Hospital is a logical focus for a community mental health center and should offer crisis-emergency services — a vital part of community mental health operations. A department of psychiatry must define, delineate, and assume the emergency responsibility for a community; the buck stops here!

OUR PAPER TODAY is not research. Rather, it precedes research — it lays a foundation upon which to build a concrete house for research.

Theoretically, the crisis school of psychology is gaining adherents. The theory posits that dealing with acute emotional crisis (a crisis = an upset in a steady state — Caplan), and with the acute phase of emotional illnesses often serves to deter or prevent chronic mental disease, at the same time building ego strength to better handle future psychic traumata. Preventive approaches, specific goal-directed (short-term) treatment, centering upon the current life situation, all are beginning to submit to and bear up under the wary eye of scientific scrutiny.

DEFINITION AND LITERATURE

An emergency can be defined in any number of ways. Anyone who phones, anyone who "walks in," anyone who is referred to the emergency service, could be automatically classified as an emergency patient. Shurley and Pokorney suggest that an emergency is always sudden and unexpected, always requires immediate attention to prevent serious damage. In essence, an emergency is defined by the urgency of the need to respond. This urgency can be felt by the patient himself, by his family, by the police, etc. Brothwood makes the crucial point that whatever the definition, the prompt assumption of clinical responsibility for the patient is expected and demanded.

In a national study of patients presenting themselves to the emergency room (6842 patients in eleven Emergency Centers), 27.3% were considered to have frank entirely psychiatric illnesses (and symptoms); another 25% manifested concurrent psychologic and "organic" — physical difficulties. Thus, at least half the patients presenting themselves for emergency care had either major or minor psychological distress.

ALTHOUGH DANGER TO self and/or others appears to be the most crucial criterion of a psychiatric emergency, we have somewhat arbitrarily divided the emergencies into six possible types: (1) suicidal — depressed; (2) homicidal — aggres-

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sional (overt violence is rare in the emergency room); (3) psychotic — reality breakdown; (4) panic — anxiety; (5) organic — confusion — delirium (e.g., drinking, drugs); and, (6) family and environmental intolerance.

As examples of the wide diversity of diagnostic categories which are (also) classified as psychiatric emergencies the suicidal, homicidal, and "excited" patients are compared. The suicidal patient may be depressed, schizophrenic, hysterical, sociopathic, or anxious. The homicidal patient may be paranoid, sociopathic, or schizophrenic. The "excited" patient may be acutely anxious or panicky, manic, catatonic, or hysterical. The "proper diagnosis" is, of course, secondary to an awareness and evaluation of the "emergency state," and the level of behavioral control is often its determinant.

"IDEAL" STRUCTURAL MODEL

Whether an emergency service is centralized, i.e., administrated and to some extent geographically represented under one aegis or whether it is "appropriately" distributed and as it were decentralized, is a moot point and depends on local issues, political and otherwise. Philosophically and technically, we favor a central locale, an integrated cohesive unit as close geographically and emotionally (attitudinally) to the medical-surgical-general emergency area as possible.

The ideal model contains five essential elements:

1. A 24-hour telephone service which should have a special Crisis-Emergency (CE) number, well publicized. This unit has five functions:
    (a) Suicide prevention.
    (b) Support, guidance, classification and advice.
    (c) Consulation.
    (d) Information.
    (e) Referral.

2. Walk-in Service (e.g., walking into the Emergency Room). Some walk-in centers are really trouble centers, handling both major and minor "disturbances"; many are store-front operations in the heart of a slum area — indigenous of the community; only a few such as Bellak's Trouble Shooting Clinic in New York City are attached to and a part of a general hospital.

3. A Crisis Intervention Clinic — four to six closely spaced outpatient interviews. A crisis team may make home visits.

4. Consultative Services.

5. "Back-up" Inpatient beds to be utilized on a flexible basis. Three units are envisioned:
    (a) For the patient to be held 4-6 hours.
    (b) For the patient to be held 24-72 hours.
    (c) For the patient to be held 1-4 weeks.

Implicit in these five elements is the concept of a collaborative-cooperative-liaison relationship with the agencies and institutions of the community. For example, collaboration assumes that an appropriate referral may be made with reasonable expectations that it will be successfully consumated.

The success or failure of an emergency service depends upon the flexible use of skilled personnel. The staff should be multidisciplinary, with both distinctive and overlapping skills, including a psychiatrist, a social worker, a nurse, a psychologist, a trained mental health worker, a secretary, and (perhaps) volunteers.

OUTPATIENT CLINIC — INNOVATION

Beginning July, 1967, the Psychiatric Outpatient Department of the University of Michigan Hospital undertook to improve service to the community, and at the same time broaden training experience for its residents, and to increase social research opportunities. The change involved a grouping and coordination under the direction of a senior staff psychiatrist, resident emergency psychiatrist, and a psychiatric social worker.

First, the team coordinated the emergency services of the Outpatient Department from 8:00 a.m. to 5:00 p.m. weekdays with identical services provided by the resident on call (ROC) evenings and weekends. An initial step was to establish brief meetings between the resident EP and the ROC twice daily. Here valuable information affecting proper services for the patient was communicated both ways.

Secondly, the resident EP manned the telephone. Incoming calls are received from patients, agencies, doctors, and relatives. Previously, entirely handled by the psychiatric social worker (who now serves primarily as a consultant on community resources), the resident takes calls requesting information, advice, and appointments for evaluation, reassurance, and possible admission. He attempts to assess the caller's needs and strengths, and makes appropriate plans for disposition. Often support, reassurance, and guidance lessen the urgency of the caller.

FOR TRAINING PURPOSES and for establishing links with the medical community, it is appropriate that the psychiatric resident take the initial telephone call.

Often communication is facilitated by a doctor-to-doctor contact. The mother of a patient hospitalized elsewhere came to the clinic requesting transfer of her daughter to our hospital. A brief interview enabled the resident EP to ascertain that the mother was reacting with strong feelings of being excluded because she had had no contact with her daughter's psychiatrist. Not only was she encouraged not to interrupt her daughter's therapy, but a call to the daughter's psychiatrist helped secure an interview for the mother.

The resident EP sees all walk-ins to the outpatient clinic and to the emergency room. The requests for help are similar in type to those received over the phone, but the presenting problem and need are more acute. Another area of service provided by the resident EP is emergency consultations to other services within the hospital. Though the immediate need is for management, there are opportunities to assist in making definitive, long-term plans to help the patient.

TIME, EXPERIENCE, AND improved communications are necessary to solve a number of problems. Almost immediately, we experienced difficulties with hospital administration policies which control setting of fees. This problem is especially poignant for the walk-in who needs to talk briefly with the resident EP. However, the policy directs that the walk-in register, pay a fee, and *then* see a doctor. Another problem is the need for short-term crisis intervention beds, perhaps two to four beds designated for such use by the resident EP. Within the general community problems also exist, e.g., the reluctance of some agencies and physicians to accept certain referrals.

PROBLEMS IN COLLABORATION and coordinating services among existing agencies must be worked out. An example is the similar, but separate and uncoordinated efforts of the various student mental health services within the university community. The student from out of state, living alone, having few friends, and in psychological, social and legal difficulties requires a solid community team effort.

Some recently collected data is used to illustrate the contacts made by the resident EP and the psychiatric social worker. In the first six-week period there were 223 contacts involving 182 cases. Of the 182 cases, 49 were seen personally and 133 handled over the phone. Without offering a complete breakdown of data, it is interesting to note the following: Of the 49 seen personally, the largest number were self-referred (1/3); 1/5 were referred by the emergency room.

If psychiatric staff were "stationed" in the emergency room, it is likely that more patients would be seen and appropriate disposition made right then and there. Additional advantages are obvious,

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including improved communications and relations with the rest of the medical, university, and outside communities. The authors have had "emergency" calls from mental health professionals, patients, and relatives about the patient having been seen in the emergency room for "physical complaints," then having been sent home without their "psychological distress" having been checked out by a psychiatrist.

After the initial contact, 1/4 of the patients were able to accept a routine appointment, and another 1/4 were able to follow through a referral to another agency. In these instances, a short but definitive personal interview effectively screened the "emergency."

Of the 133 cases handled over the phone, the observations are similar. The largest number (2/5) were self-referrals; a significant number (over 1/4) were referred by physicians. Here the data suggest that after initial contact with the doctor, the caller was most often able to accept a routine appointment (over 1/2), or information and recommendations (1/3).

A limited "follow-up" study suggests that the emergency disposition made by the resident EP was successful. Of 92 patients given appointments over this period, only 12 failed to keep their appointments. Of 20 referrals made to other agencies, only 3 patients failed to carry through. Of 51 patients given information and recommendations, 49 considered the information helpful and followed the recommendations.

THE TROIKA

The functions of a University Medical Center are training, research, and service. These three need to be considered as an integrated package.

This new venture of the Outpatient Psychiatric Clinic provides an unparalleled training opportunity in community psychiatry for residents and (potentially) for many mental health disciplines. Andre contends that the duties of the resident EP can be viewed as an elaboration of the experience gained working with the "community" of inpatients. The same experiences of diagnosis, treatment, planning, organization, and decision-making as a team member are broadened and intensified. By mobilizing and coordinating forces, the resident learns that hospitalization can indeed be prevented.

A 53-year-old schizophrenic man, living alone, but hearing voices for the past four years came to the Outpatient Department. Previous contacts with two agencies resulted in identical recommendations — that he go voluntarily (or involuntarily) to a state hospital. By coordinating efforts of two agencies with his own efforts, the resident EP was able to provide medicine, outpatient therapy, and community support, and the man continues to work regularly and is improving.

THE RESIDENT DEVELOPS flexibility through shifting role functions, e.g., as therapist, consultant, and administrator. Training in decision-making and the exercise of authority with good judgment is given the resident EP through his experience and through his daily supervision by a member of the senior staff. There is ample exposure to enhance the *general* training of all residents, and, for some, it will stimulate interest in further subspecialization in community psychiatry.

Ideally, a psychiatric resident should be assigned to the emergency room during the day, then to be on immediate call after 5:00 p.m. He could be in his 2nd or 3rd training year, the rotation integrated into the regular three-year residency training program. Besides receiving training, he would teach the intern and several (Senior) medical students assigned to the emergency room.

The research potentials are enormous. Besides measuring what it is doing, a University Hospital Psychiatric Emergency Service could gather data re community needs, resources, and their utilization. Collection and interpretation of epidemiological data are fair game for a University Emergency Service serving the community. The origins and process of emerging (psychologic) illness, the role of crisis in ego development, and experimentation with new treatment techniques are only a few of the crucial issues to be examined. The mental health student (of whatever persuasion) should be involved in research effort as part of his basic training program.

By establishing closer and warmer relationships with the rest of the community, the University gains added community respect *and* self-respect. It, thereby, serves its students, faculty, and the people of the State well.

FINIS

By our own present definition of the treatment of a psychiatric emergency, the preliminary study done by Andre (as well as a more definitive study recently accomplished by Neal) suggest that we have been "successful" — people are getting *immediate* help.

Evidence is mounting that immediate help is real and that improvement in symptoms and functions is often maintained. Implicit in this paper is the hope that the ideal model described will be implemented and translated into a real model.

Adults tend to envy adolescents because adolescents have not *yet* wasted their opportunities. Let us not waste ours!

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Editorial Note:

This article should point out to those in charge of Emergency Room Service the need and possible solutions to psychiatric problems. It is also worth noting in this modern day when forces on all sides suggest "total involvement" that psychiatrists are taking a look at the overall medical picture and are suggesting their own involvement in the acute care of patients.

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Medicine and the Law

ABSTRACT -- The divergencies in the philosophies and practical applications of medicine and law in their interrelation must be reconciled to obviate procedural and semantic differences in approach. The objectives, helping patient and client, are at one in motivation. Exchange education between the professions regarding the processes of each would be helpful. Practical aspects of the application of medicine and law are being sought through four major plans now operative. These are described and discussed.

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PHILOSOPHIES OF LAW AND MEDICINE

The art of medicine and the philosophy of law must be intertwined, for 80 percent of all trial cases require medical proof.

Medicine has passed through three stages of development: diagnostic, preventive, and rehabilitative. Medicine's purposes are to maintain the patient in good health, to overcome disease and injury, and to lengthen his life span. Medicine evolves from the laboratory and clinical application by scientific process. Law's purposes have been peace and order and the pursuit of truth for justice, including the safeguarding of human rights and the concept of equality of opportunity. The two professions must serve the whole man. Their common goal is the pursuit of truth.

Justice Felix Frankfurter was rightly critical in saying: "Doctors and Lawyers follow their calling too narrowly; they live too exclusively within the professions; they do not cultivate enough intellectual detachment." The great need in both professions is not specialized practitioners but rather civilized practitioners to serve the common denominator — man.

People follow medicine; the law follows people. Patients accept new preventive, diagnostic, and therapeutic practices with reliance on and faith in their physicians. The community may refuse to accept new legal rules of conduct in the administration of justice; thus, new decisions for orderly progress of law may follow. Law undergirds its laws with the community mores, experiences, customs, and culture. This explains why people follow medicine but although they must be led by law, in the sense of the law's insuring stability, the law follows the demands of the culture of the people.

The philosophies showing the general relations between law and medicine have been classified as divisive factors by Mr. Oliver Schroeder, Professor of Law at Western Reserve University, Cleveland, Ohio. They are grouped under: (1) purposes, (2) relationship of patient and client, (3) semantics of medicine and law, (4) rate of advancement of law and medicine, (5) problem of how to bring the two professions together.

RELATION OF PATIENT TO PHYSICIAN OR CLIENT TO LAWYER

The physician serves the human being, primarily influenced by nature but always mindful of the health of the other members of the environment. The lawyer serves his client but the influence of the rights of other human beings must be preserved. The comparison shows more similarity of motive than differences of objective. Both professions serve the human being from a completely different approach, but both emphasize the integrity of the human being.

SEMANTICS IN MEDICINE AND LAW

A major divisive element between the physician and the lawyer is in semantics. This is because of the differences in emphasis, the separate professional terms of reference affecting meanings, and because of the differing responsibility of the professions to patient and client.

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Because medicine contributes to the administration of justice, it is necessary to understand the medical-legal terms. Such an understanding prevents the physician's conflict with the legal rules and statutes. Semantic reconcilement of terms of reference is mandatory. Terms have been appropriated to connote the application of medical knowledge to the administration of law and justice: "Forensic medicine," which originated in England; "legal medicine," which is of French origin; the "Gerichlichte Medezin" of the Germans, and "medical jurisprudence," an American term for the application of medical and surgical knowledge and skills to the principles and administration of law, comprising legal subjects having a medical aspect; thus, medical jurisprudence.

In general, it is necessary to have semantic understanding of medical-legal responsibility in relation to the four major groups involving the physician: (1) the medical organization, including State licensure, medical organization relations within medical societies, hospital management associated with staff functions and duties; (2) criminal law and its relation to forencis pathology and psychiatry and physiatry; (3) insurance in civil law in which the physician is most involved: personal injury (mostly in automobile accidents) and workmen's compensation and third party actions (usually associated with public building accidents) ; or malpractice in its many manifestations; (4) public health and industrial medicine, including pure food and drug activities, social security laws, and functioning of federal agencies under general tort laws.

Physicians consider that certain factors may produce illness even when the influence of those factors is only minimal. Those factors, whether etiologic, predisposing, or precipitating, must all be handled medically regardless of which is actually causative. Law requires only that 51 per cent probability of casual factors be present for legal responsibility. Hence a charge by a judge to a jury would be: "If you find the preponderance of evidence, which means the greater weight of evidence, that the plantiff's physical condition was caused by the accident, you should find for the plaintiff." When the same words and the same concepts have different meanings, they do tend to separate people and professions, causing discord. Dr. Keith Simpson, eminent physician and legal counsel expert in England, has indicated that one rarely hears the supporting tactics: "That is not what I mean; what I was asking you, Doctor, was . . . " Dr. Simpson cites the only exception to this in the expert's testimony: "If counsel deliberately misphrases a reply in order to mold evidence to his case, he must be corrected. He will accept the rebuff with a wry smile."

Regarding the judge in relation to hypotheses, one might ask how the judge can permit the attorney to put so-called facts, which are really assumptions, to a witness to clarify a situation: "Just assume, Doctor, that swallowing of 7 grains of sodium arsenite did not have an effect," and then, if not stopped, the counsel could continue his hoodwinking. One should refuse to entertain such opinions unless ordered to do so by the Judge.

RATE OF ADVANCEMENT OF MEDICINE AND LAW

Physicians and scientists are accustomed to rapid progress in resolved areas of endeavor. They have difficulty in understanding the slow progress of practical law. Although break-throughs in basic research have been historically slow, they are not so slow as they were before the last half century. When a breakthrough has been experimentally valid, clinical application is rapid. The lawyer cannot always appreciate the increasingly rapid change in scientific concepts; hence, in cross examination, he may fail to understand why a physician's conclusion may have changed drastically from year-to-year during a protracted case.

HOW CAN THE TWO PROFESSIONS BE BROUGHT TOGETHER?

The physician and the lawyer, medicine and the law, must be pivotally, not tangentially, oriented. This can be done. As a result of interaction between the American Medical Association and the American Bar Association, functioning has become reciprocally helpful at the levels of the State Medical Society, the County Medical Society, and hospital groups.

The physician must cross over to the side of the law by accepting the responsibility of being a medical witness in court who provides truthful facts and admissible opinions to aid in the administration of justice. The lawyer must cross to the medical side to aid in the preventive, diagnostic, and therapeutic tasks of medicine. This means that the lawyer and the physician must attempt to resolve legal conflicts speedily, in order to prevent iatrogenic complications, and to get the best medical recovery of the patient and the best legal disposition for the patient. In workmen's compensation accidents, a fixed disorder may be precipitated on a non-organic basis — an iatrogenic disease. The concept of participation must be furthered by: (1) education at schools of medicine and law to permit students to gain a thoroughly understanding concept of the processes at work on each side; (2) professional societies where intermingling and exchange of information may improve cooperation; (3) instruction and research through publications, as is now being done also in the state journals of medicine and law in order to insure the exchange of information between the professions.

PRACTICAL ASPECTS OF THE APPLICATION OF MEDICINE AND LAW: OPERATIVE PLANS

At times physicians have accused attorneys of promoting malpractice claims when an attorney attempted to secure expert advice in testimony in problems related to personal injury or malpractice. In turn, at times attorneys have accused physicians of a "conspiracy of silence." Judges on their part have retaliated in some areas with the concept of the *res ipsa loquitur* doctrine in order to permit the plaintiff's attorney to bring a case to trial. As personal injury suits increased and the need for expert medical testimony increased, physicians often have been averse to appearing in court. The physician is placed in an atmosphere entirely foreign to his training. He is accustomed to presenting his information according to accepted scientific procedures, basing his conclusions on observation of medical data studied. He is accustomed to the privilege of speculative interpretation from all points of view, all possible alternatives, without dogmatism. In the legal adversary system, the replies of the physician to a series of questions in court must be dogmatically in the affirmative or in the negative, unequivocally and without qualification — an unthinkable position to take in medical reporting. Thus an experienced trial attorney, if he chooses, is able to modify, to distort the actual medically factual account. If the medical expert uses the word **opinion,** counsel may suggest that the reply is **guesswork.** The medical **view** becomes to counsel by **conjecture;** medical use of **belief,** counsel may dismiss as **theory;** if the physician is **convinced,** the counsel calls it prejudice; a suggestion of **cooperation,** becomes at least a hint of **collusion.** What the expert considers **logical,** counsel may concede is **plausible,** or what seems medically **self-evident,** is disparaged as **glib.** An accepted **current view** in medicine is denigrated as present-day **theory.**

Both personal injury and malpractice may represent negligence to the legal mind. It should be a responsibility of the physician in furnishing the expert information to define and differentiate, and it should be the responsibility of the legal procedure to allow latitude for such clarification. This would obviate the concept of the so-called **impartial medical witness.**

Several plans are in operation to further understanding between physician and attorney. These are outlined under four media of consideration: (1) Medical Review Committee; (2) Joint Physician and Attorney Review Panel; (3) Expert Witness and Advisory Panel (California Plan); (4) American College of Legal Medicine.

1. The MEDICAL REVIEW COMMITTEE is the usual constituted type of organization made up of physicians in a local medical society. This committee reviews the case and recommends either for defense or settlement. When the recommendation is for defense, help is given to the physician to organize the defense.

2. The JOINT ATTORNEY-PHYSICIAN REVIEW PANEL is operatively mainly in Arizona and is known as the PIMA plan. The local Bar and Medical Societies have joined hands professionally. The panel is made up of nine physicians and nine lawyers; the defendant and his attorney, and the plantiff and his attorney participate. When a claim of negligence or malpractice is advanced, the chairman of the local joint group is notified, and he sets a date for a pre-trial hearing before the joint panel. The claimant may present his case, and may include hospital records; the defense may give his version; witnesses may be heard on both sides. The panel considers the evidence, and considers whether the evidence of serious injury arising out of malpractice is or is not substantial. If the answer is in the affirmative, an attempt is made toward an equitable claim adjustment; if this cannot be achieved, the medical soci-

ety produces the needed expert during trial. If the answer is in the negative, the plaintiff attorney is not to post or file a suit. The records of the panel are confidential and official records are not kept. This plan is also functioning in Idaho, New Mexico, New York, Nevada, Pennsylvania, and Virginia. It has been operative for 10 years.

In the functioning of this plan the potential of litigation is in the hands of the plantiff attorney and plaintiff as is evidenced by exposure of all records to the plantiff attorney at an early stage, which may give him an undue advantage. If the lawyer agrees not to represent the client, the client is still free to go to another attorney, utilizing the confidential material divulged at the panel hearing. In small communities, because the professional and social relations are close, the Joint Attorney-Physician Review Panel works well.

3. The EXPERT WITNESS AND ADVISORY PANEL is generally known as The California Plan. It is operative in a number of communities through the State of California. It also is being used in the State of Utah, where variations for using witnesses in malpractice cases are under community consideration.

In the California Plan, County Medical Societies furnish a panel of expert witnesses to the plantiff attorney. Precedents for this are in Los Angeles, San Diego, and San Francisco. The panel of physicians is drawn from the different specialties. The individual physician reviews all the records, examines the patient, and forwards a written report to the attorney. Should the attorney be dissatisfied with the method of the physician, he has the right to petition for another physician who then would be assigned to him. The responsibility of the physician is to testify if a case goes to court. This is obligatory. During the process of testifying, he must not make reference to the panel or to the combined Bar and Medical Societies' participation. The physician is paid a reasonable fee for consultation, examination, review of records, reports, and his function as an expert witness.

This plan has a divisive effect on the medical profession. Moreover, it does nothing for the defendant physician. Further, it fails to eliminate the nuisance suit.

4. PLAN OF AMERICAN COLLEGE OF LEGAL MEDICINE. All members of the American College of Legal Medicine are graduates of law schools as well as being practicing physicians.

PRINCIPLES:

A. Elevate standards of legal medicine and sponsor medical-legal research in order to reduce baseless suits.

B. Offer services as disinterested third parties to attorneys, in evaluating the malpractice problem

(1) Learn clinical facts and apply them to existing law.

(2) Neither to seek excuses for the physician nor to build a case for the patient.

(3) Show that there is no conspiracy of silence, a charge arising from a large number of baseless suits, so that a natural reluctance for physicians to testify resulted.

These principles reflect the uncivilized history of the resolution of complaints of malpractice.

PROCEDURE:

A. Assign case histories to members in rotation, each to examine material and send to appropriate medical experts and legal experts. Materials are sent to patient's attorney and to his physician.

(1) The committee gives an opinion regarding whether prosecution of the lawsuit will be successful. The presumption is that the average lawyer will not sue.

(2) Insurance companies will be likelier to settle dubious claims; hence, benefit the physician. Also, the insurance company would be advised to settle the claim when justified.

(3) If the claim is just, the opinion being unbiased, the physician is more inclined to insist on an out-of-court settlement.

B. Anonymity: Participants' names in the American College of Legal Medicine are not available. Names of parties to the suit are not available.

Medical-legal Dissection

Functioning in the fashion described, the American College of Medicine intends to remove baseless suits, on the one hand, and afford justice to the injured on the other hand. This concept tends to remove some of the existing threats to good medical care.

The American College of Legal Medicine Plan does not eliminate problems of "products liability." The newer legal concept is to include the physicians because some pharmaceutical companies may be using "stuffings" to escape liability. The plan does not eliminate malpractice suits in which medical experts are not needed, such as in assault and battery, breach of warranty, or consent and abandonment.

SUMMARY AND CONCLUSIONS

What works in one community may not work in another. Plans to further understanding between the professions and to eliminate nuisance lawsuits now operative are: The Medical Review Committee; The Joint Attorney-Physician Review Panel; The Expert Witness and Advisory Panel (The California Plan) ; The Plan of the American College of Legal Medicine. These plans are described and their limitations indicated.

Responsibilities of orientation through the press and films sometimes boomerang through misinterpretation. The client may insist on claims. The patient's feeling of having been wronged may have nothing to do with medical procedure, as in technically open areas, such as assault and battery, breach of warranty, criminal procedures against the physician, consent areas not requiring a medical expert.

Participation between the professions would be facilitated by education at professional schools regarding the processes of each profession, by intermingling of legal and medical societies for exchange of information, and by publishing in each other's journals.

Medicine must be looked to to provide medical truths and truthful opinions to settle or adjudicate legal conflicts. Law must cross over to the side of medicine to aid in the physician's preventive, diagnostic and therapeutic tasks. This can mean resolving legal conflicts speedily, thereby permitting the best medical recovery of the patient-client. Semantic reconcilement of disparate terms would reduce professional divisiveness. Medicine should have the legal privilege during testimony of scientific qualification of procedurally imposed dogmatic "yes or no" responses.

Editorial Note:

At the present time all physicians in Michigan are cognizant of the costs of Malpractice Insurance and the reason for such costs. We must find some solution to the problem of malpractice suits.

—John W. Moses, M.D., Scientific Editor

Non-Diabetic Glycosuria

(Note: This is one of a series of brief comments concerning problems seen in patients with Diabetes Mellitus. Members of the Clinical Society of the Michigan Diabetes Association will be supplying this material at frequent intervals. Readers of this Journal who care for diabetic patients will benefit by looking for these presentations of clinical importance and usefulness.)

BY WALTER ANDERSON, M.D.
DETROIT

We usually mean renal glycosuria when a patient has glycosuria with a normal blood sugar and a normal glucose tolerance test. Often the criteria also includes glycosuria in the fasting urine. This condition may be familial due to a defect in the renal tubular absorption of glucose. Some authors have reported, in long-term follow-up studies, that as high as 63% of patients with non-diabetic glycosuria may develop diabetes. Therefore, this group should be tested frequently for diabetes.

Acquired renal glycosuria may be seen in pregnancy; from 10 to 25% of such patients have been reported to have a non-diabetic glycosuria due to an increase in glomeruler filtration or a decrease in tubular reabsorption of glucose.

During the use of glucocorticoids, glycosuria may be found. Glycosuria also may be present in association with certain central nervous system disease, nephrosis, myocardial infarction, hyperthyroidism, disease of the liver and post-gastrectomy states. A glucose tolerance test is always necessary to rule out diabetes in these cases.

Other sugars, as fructose, galactose, lactose, pentose, and mannoheptulose may appear in the urine and give a positive test for sugar with one of the copper-reducing reactions (clinitest, Benedict's). Therefore, one of the glucose oxidase reactive tests (clinistix or tes-tape) should be used to specifically indicate the presence of glucose.

Too often a patient with a positive urine test will be advised to have only a fasting blood sugar. Frequently this will be normal and the patient assured he does not have diabetes. This is well illustrated by the following case:

A 59-YEAR-OLD WHITE male was found to have glycosuria and had a glucose tolerance test. He was told this was normal and he had renal glycosuria and not diabetes. During the following 25 years sugar was found in his urine on at least five occasions. He had five fasting blood sugars and was told that they were normal, always then being reassured that he had renal glycosuria.

These fasting blood sugars were 120, 128, 120 and 116 mg. per 100 ml. One 2-hour postprandial sugar was 157 mg. per 100 ml.

This patient was seen on November 12, 1967 with a typical history of claudication of right leg after walking one block. Physical examination showed a well-developed, well-nourished white male; height 6 ft., weight 190 pounds, stripped. Examination was essentially negative except for the lower extremities where both feet were cold to palpation; there was marked pallor of the right foot on elevation. Popliteal and dorsalis pedal pulses were absent bilaterally while the right posterior tibial pulse was absent and the left one diminished.

Oscillometer readings: Right ankle, zero; right calf ½ unit; left ankle, zero; left calf, 2 units.

The fasting blood sugar was 118 mg. per 100 ml. (true glucose). Urine was negative for sugar. A three-hour glucose tolerance test after a high carbohydrate diet for three days revealed:

	Blood*	Urine**
Fasting	122	Negative
½-hour	194	trace
1-hour	256	4-plus
2-hours	242	4-plus
3-hours	238	4-plus

*mg. per 100 ml.; **qualitative glucosuria

The blood urea nitrogen (BUN) was 12 mg. per 100 ml. and the cholesterol was 262 mg. per 100 ml.

This patient was put on a diabetic diet of: Protein 90 grams, Fat 70 grams, Carbohydrate 160 grams, totalling 1630 calories. 15 units of NPH and 15 units of regular insulin was given before breakfast each morning. On discharge a 2-hour postprandial blood sugar was 100 mg. per 100 ml.

DIABETES IS THE most common cause of glycosuria; therefore, any patient with glycosuria should have a glucose tolerance test. Even a 2-hour postprandial blood sugar may not be adequate, for in early diabetes this may be normal. A diagnosis of renal glycosuria should not be made unless it fulfills the diagnostic criteria of glycosuria in a fasting specimen with a normal blood sugar and a normal glucose tolerance test.

We must also remember that about 60% of the cases of glycosuria will eventually have a diabetic-type glucose tolerance test if followed over a number of years.

The Author, Doctor Anderson is an attending physician at Harper Hospital, Detroit.

Are You Participating, Too, In Search for Solutions?

BY JAMES B. BLODGETT, M.D.,
SPEAKER, MSMS HOUSE OF DELEGATES

The following comments might be the personal code for every physician — but how often are they?

> *"If I am not willing to participate in the search for the solutions to the problems of the times then I have relinquished this privilege to others who are willing to become involved.*
>
> *"If I am not pleased with their solutions to the problems I shall have no recourse nor any right to criticize."*

How often have you heard a physician voice those views rather than gripe and complain?

How often have you heard a physician make this kind of statement?

> *"If my children grow up and find this society an undesirable world in which to live they will ask me what did I do to protect it and to improve it for them and I must be able to answer, 'I did the very best I could.'"*
>
> *"I believe that we must be involved in the action and passion of our times or we shall run the risk of being judged not to have lived."*

The above comments were made at least by one Michigan physician . . . Jack M. Stack, M.D., of Alma. We refer to them here not only to pay tribute to Doctor Stack but to help set some high standards for all MSMS members.

These comments were offered humbly by Doctor Stack when he received the coveted Michigan Jaycee "Outstanding Young Man of the Year Award." Five such awards are given each year on a statewide basis and Doctor Stack is the only doctor of medicine so honored.

Doctor Stack, in receiving the award, pointed out:

> *"Many of our cynical friends question the validity of contributing a large segment of one's energies to community service, to partisan politics, and to professional organizational responsibility."*

As expected, Doctor Stack viewed the award as a new challenge:

> *"In my mind I shall consider this award to signify more than recognition of past accomplishments."*
>
> *"This award will parallel those other events in demanding of me increased participation, in offering new challenge and in exacting greater responsibility."*

On behalf of all MSMS members, I want to offer hearty congratulations to Doctor Stack who is serving now as president of his Gratiot, Isabella, Clare County Medical Society, as an alternate delegate to the MSMS House of Delegates, as vice president of the Alma Chamber of Commerce, as a member of the MDPAC Board of Directors and a finance chairman for the 10th Congressional District of the Michigan Republican Party.

Let's Boost MSMAS

BY G. E. MILLARD, M.D., CHAIRMAN,
MSMS ADVISORY COMMITTEE TO MSMAS

"Progress through Professionalism" will be the theme for the 1968 convention of the American Association of Medical Assistants with several Michigan ladies playing prominent roles.

More Michigan medical assistants will be able this year to make the short trip to the AAMA meeting in Columbus, Ohio October 9-12. All who attend the combination business-educational convention will benefit. Their physician-employers too will benefit as the medical assistants increase and improve their knowledge and insights.

The AAMA House of Delegates again will consider proposals for expanded programs. Michigan will be proud to have Betty Lou Wiley, of Port Huron, a past president of the Michigan State Society of Medical Assistants, preside as Speaker of the AAMA House of Delegates.

The AMA House of Delegates in San Francisco again praised the AAMA, noting that the group has grown to 12,000 members in less than 10 years. The AMA resolution, in part, urged every physician "to become fully acquainted with the objectives and programs of the AAMA, and to encourage his own assistants to seek membership in the national association and its local and state affiliates, and to participate in their education and certificate programs."

Physicians should stimulate membership and participation in the MSMAS and its local units in Michigan because the organization helps train the assistants and helps develop effective allies in many MSMS efforts in legislation, communications and medical education.

Many articles and photos about the MSMS House of Delegates and Annual Session will appear in the October News Extra and the November issue of Michigan Medicine.

See Page 1243 about "Outstanding Physician of the Year Award" to Marjorie Peebles Meyers, M.D., of Detroit.

MAGP Symposium On Immunization Set Oct. 6 at MSU

About 350 physicians are expected to attend the Symposium on Immunization sponsored by the Michigan Academy of General Practice Sunday, October 6, at the Kellogg Center in East Lansing.

After lunch Andrew D. Hunt, Jr., M.D., Dean of the Michigan State University College of Human Medicine, will speak on "How to Graduate More Family Physicians."

The program is acceptable for 6 prescribed hours by the American Academy of General Practice.

Physician's registration fee, including lunch, is $10.

MSMS-MHC to Sponsor Careers Workshop Oct. 23

Officials from many Michigan universities and health associations have accepted invitations to speak at the Health Manpower Conference, October 23 near Battle Creek.

The Michigan State Medical Society and the Michigan Health Council, joint conference sponsors, have invited representatives of county medical societies, hospital board members, hospital administrators, school counselors, community college officials, county supervisors, nurses and other interested in health manpower.

The program, which will run from 9 a.m. through dinner, will be held at the Michigan Education Association Conference Center on St. Mary's Lake.

Robert E. Rice, M.D., Greenville, Chairman of MSMS Committee on Rural Medical Service, will preside as chairman.

Copies of the complete program are available by writing MSMS, 120 W. Saginaw, E. Lansing 48823.

Among the many speakers will be Milford O. Rouse, M.D., Texas, past president of the AMA; Lionel F. Swan, M.D., Detroit, president of the National Medical Foundation; Charles Skinner, Jackson, president-elect, Michigan Hospital Association.

Also, William H. Knisely, Ph.D., East Lansing, member, National Advisory Council on Education for Health Professions; Robert Kinsinger Ed.D., program director, W. K. Kellogg Foundation. MSMS and MHC officials will participate.

Smoking-Health Speakers Set For Oct. 20

Topics ranging from smoking-related diseases to steps that may help smokers break the habit will be covered at the Physicians' Symposium on Smoking and Related Diseases Sunday, October 20, at MSU's Kellogg Center in East Lansing.

The session, designed especially for general practitioners, will include discussions of Vascular Diseases, Respiratory Diseases, Cancer of the Lung and Smoking Cessation Methods.

It will open with a welcome address by Lee Feldkamp, M.D., president of the Michigan Academy of General Practice, and remarks by George Pickett, M.D., deputy director of the Wayne County Health Department and former assistant director of the National Clearinghouse on Smoking and Health.

Speakers at the morning session are Vernon Wendt, M.D., of Grand Rapids, who will discuss "Cardiac Complications," and E. Osborn Coates, Jr., M.D., of Detroit, speaking on "Respiratory Diseases."

An afternoon session on lung cancer will include: "X-ray Diagnosis of Lung Cancer," Charles O. Long, M.D., Lansing; "Clinical and Surgical Evaluation," Cameron Haight, M.D., Ann Arbor; and "Pathology of Lung Cancer," R. Abell Murray, M.D., Ph.D., Ann Arbor.

Alfred Soffer, M.D., editor-in-chief of *Diseases of the Chest* will discuss "National Approaches to Smoking Cessation and What the Office Practitioner Can Do," and Arthur Weaver, M.D., Detroit, will outline methods of smoking cessation.

Roundtable discussions will follow both the morning and afternoon programs.

Sponsors of the symposium include Michigan Academy of General Practice, Michigan Council on Smoking and Health, Michigan Health Council and MSU's College of Human Medicine, and other health-related organizations.

Battle Creek Clinic Day Program Set

A Western Reserve University surgeon will describe medical problems that exist in remote sections of Australia and New Guinea when he delivers the feature lecture at the annual Southwestern Michigan Clinic Day Thursday, November 7, in Battle Creek.

Brown M. Dobyns, M.D., professor of surgery at Western Reserve, will deliver the annual Russell L. Mustard Memorial Lecture to conclude the day-long event at the Battle Creek Country Club.

The lecture is sponsored by the Calhoun County Medical Society.

The Clinic Day, which begins at 9 a.m., will be devoted to a Symposium on Cancer Therapy, sponsored by Lederle Laboratories.

Speakers and their topics include: Edward G. Krementz, M.D., of New Orleans, "Advances in the Diagnosis and Treatment of Melanoma;" David M. Sklaroff, M.D., of Philadelphia, "Recent Advances in Radiation Therapy;" Richard A. Oberfeld, M.D., of Boston, "Prolonged Intra-arterial Infusion Cancer Chemotherapy for Advanced Cancer;" and Charlotte T. C. Tan, M.D., of New York City, "Solid Tumors in Children."

Following the lectures will be round table discussions involving the four speakers, with ample time for questions and comments, according to Robert W. Brown, M.D., chairman of the Clinic Day committee. Also scheduled is a noon luncheon.

Interested MSMS members in Southwestern Michigan are invited. Programs are available from Robert W. Brown, M.D., 231 North Avenue, Battle Creek 49017.

HEW Issues New Report on RMPs

The following box-score has just been released by the U.S. Department of Health, Education and Welfare to give the current status of the Regional Medical Programs to implement the federal heart-stroke-cancer legislation:

Twenty-three Regions are now operational. They include the 10 most recently funded operational Programs which are . . .

California
Central New York
Georgia
Iowa
Maine
Memphis
Michigan
New Mexico
South Carolina
Texas

One new planning grant has been awarded to the Puerto Rico Regional Medical Program.

Applications from a total of 11 Programs to become operational are in the review process.

Continuing and supplemental planning and operational grants have been made and others are under review.

Bronson Clinic Coming Oct. 16

Physicians in Southwestern Michigan are invited to attend a conference devoted to "Current Concepts of Renal Disease" Wednesday, October 16, in Kalamazoo.

It will be the ninth annual Clinical Conference at Bronson Methodist Hospital. Registration is at 8 a.m.

Speakers will include John P. Merrill, M.D., of Boston; Charles V. Pryles, M.D., of Brooklyn; Thomas F. Meaney, M.D., Cleveland; and Conrad L. Pirani, M.D., Chicago.

MSU Adds Research Scientist from NIAID

Norman B. McCullough, M.D., research scientist with the National Institute of Allergy and Infectious Diseases, recently joined the MSU College of Human Medicine as professor of microbiology and public health and professor of medicine.

Doctor McCullough, who spent the past 10 years as chief of the Laboratory of Bacterial Diseases, is known internationally for his studies in Brucella.

Manpower Act Signed, Extends Only Two Years

Physicians related to the three Michigan Medical Schools are especially interested in the details of several bills signed into law by the President.

President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the federal programs of aid to medical and allied health schools.

President Johnson termed the health manpower law "a major measure in the battle for better health." It authorizes about $1.2 billion in federal aid to medical and other health personnel schools over two years for construction, expansion and operating expenses. Congress followed most of the Administration's proposals in approving the legislation but limited the extension to two years, instead of the four years requested.

Schools of pharmacy and veterinary medicine were made eligible for the first time.

Money authorizations for schools in the new law includes:

Medical and other health professions — construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

Southwestern Michigan Study Indicates Need for 25 Per Cent More Doctors

Michigan should have 25 per cent more doctors just to meet present needs, a study by the Michigan Health Council indicates.

Preliminary results of a medical manpower study in 14 Southwestern Michigan counties show the counties a need of an additional 268 physicians if they are to meet current demands for medical services.

"The need for nearly 25 per cent more medical doctors comes as no surprise to the Michigan Health Council," comments John A. Doherty, MHC executive director.

"Nearly every day we receive calls from doctors and other health leaders asking for help in obtaining additional doctors for their communities. Some doctors are becoming desperate about their situations. Some medical doctors with many years of specialized training in surgery and other medical specialties are having to go back to general practice because of the acute shortage of family physicians."

Physicians and hospital administrators who took part in the study estimated a need for 89 additional general practitioners and 179 medical specialists. They reported opportunities for 36 trained in internal medicine, 25 pediatricians, 22 psychiatrists, 18 obstetrician-gynecologists, and 11 general surgeons.

There are currently 1,122 paysicians within the 14-county area, 410 general practitioners and 712 specialists, serving a population of approximately 1.32 million, reports Mr. Doherty.

More than 95 per cent of the doctors interviewed believe the shortage of physicians would be helped immeasurably by expanding the two-year College of Human Medicine at Michigan State University to a full four-year, degree-granting institution. They also felt that medical schools at Wayne State University and the University of Michigan should be expanded.

Students currently enrolled in medical schools should be encouraged to pursue careers in family or clinical medicine, the survey participants said.

If the Southwestern Michigan survey requests, Mr. Doherty said, are projected for all of Michigan, the state would need upwards of 2,500 more practicing physicians. This alarming figure is much worse than a 1966 estimate by the Michigan Health Council which predicted the state was some 600 doctors short of meeting present medical needs of its citizens. An expanding population will probably make the future patient-to-doctor ratio even worse than the present 820-to-1, Doherty predicts.

The study was conducted with a grant from the Michigan Foundation for Medical and Health Education in the counties of Allegan, Barry, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Ingham, Jackson, Kalamazoo, Lenawee, St. Joseph and Van Buren.

Two Bond Issues On Fall Ballot For Recreation

BY ELMER WHITE
EXECUTIVE DIRECTOR
MICHIGAN PRESS ASSOC.

Michigan voters on November 5 will be asked to support the "Michigan Quality Recreation Proposal."

There will be two proposals, not dependent upon each other. One will be a $100 million recreation proposal and the other a $335 million water pollution control proposal. If authorized by voters, the state will bond itself for the $435 million.

PROPONENTS STRESS that the bonds can be sold with no increase in taxes. Retirement of other bond issues and economic growth will provide enough revenue to cover principal and interest payments within the present tax structure.

The $30 million earmarked for local recreation facilities would be available to communities on a matching basis with the state paying 75 percent of costs. The remaining $70 million would be spent for state parks, fishing areas, fish hatcheries, forest campgrounds, hunting areas, hiking trails, snowmobile trails, etc. Combined with local and federal funds, and estimated $170 million will be available for recreational purposes.

CLEAN-WATER PROPOSAL, if approved by voters, will help finance new sewage treatment plants, improvements to existing plants, and loans for new sewers. Some 150 communities are currently in violation of Michigan's pollution control law. These communities would qualify for 50 percent assistance from the state and 25 percent from the federal government in instituting a pollution control program.

About $50 million would be earmarked for sewer construction and $285 million for treatment plant construction and improvement. The addition of federal and local funds would provide more than $600 million to clean up Michigan's lakes and streams.

Now Is the Time For All Good Men

BY VERNON V. BASS, M.D.
CHAIRMAN, MDPAC

All of us know that government is deeply involved in planning, producing, and financing health care.

Approximately 2,000 bills of interest to medicine were introduced in the U.S. Congress this year, as were over 150 health bills in the Michigan Legislature.

The responsibility for endorsing, financing and helping to elect wise, dependable political candidates who will listen to the views of the medical profession before voting, rests primarily upon MDPAC and AMPAC.

Your state MDPAC committee has carefully assessed the voting records of all legislators and by election day, November 5, will have supported over 50 candidates for the Legislature as well as several key Congressmen. There are several candidate support committees of doctors and their wives actively helping in vital congressional races.

MDPAC can only succeed in doing an effective job of campaigning in ratio to the amount of financial help it receives from doctors of medicine.

May I urge each of you to assume your political responsibility first by becoming a contributing member of MDPAC-AMPAC and secondly by your political participation to help us select, elect and retain the best men we can get in office both in Lansing and Washington!

If you are not already a member, please join today.

Doctors Permitted To Subscribe Only For Blue Cross

Michigan Blue Cross-Blue Shield has sent the following memo to physicians in the Blue coverage group:

Since the recent implementation of the Blue Shield MVF-2 program in the Michigan State Medical Society some doctors have requested that they be permitted to retain only their Blue Cross coverage and not purchase the Blue Shield program.

Those of you who choose to carry Blue Cross only may do so. Appropriate refund back to August 1, 1968, will be made.

The Blue Cross plans available are:

1. Comprehensive hospital, which provides 365 days of care with optional "special dependents" coverage (Riders S & F).
2. Deductible hospital coverage ($50 per adult member per hospital bed-patient admission) with 365 days of care with "special dependents" coverage (Riders S & F).
3. Those members 65 and older may elect Blue Cross "65" complementary coverage which is designed to fill the gaps in Medicare.

Members of the Society desirous of exercising the above options should make their request promptly and in writing to: Central Correspondence Department — Mail Code 60, Michigan Blue Cross and Blue Shield, 441 East Jefferson Avenue, Detroit, Michigan 48226.

Wide Variety Of Topics Set For AMA Meet

Scientific sessions of wide medical interest are planned for morning and afternoon Monday through Wednesday, December 2-4 at the 22nd AMA Clinical Convention in Miami Beach, Fla.

Topics December 2 include the anemias, thrombophlebitis, obstetrics, white cell disorders and diseases of the lymph nodes, management of claudication, cerebral ischemia due to neck vessel occlusion, and gynecology.

Subjects for December 3, are cardiology, gastrointestinal diseases, proctology, and — in the afternoon — new approaches in cardiology, bacterial skin infections, and the skin and sunlight.

Discussions on sex will be held December 4, to include such topics as marital problems, changing sex values, preadolescent and adolescent sex education, and sex and the senior citizen. Other topics December 4 will be hypertension, kidney, pulmonary diseases, and respiratory ills in children.

Scientific sessions will be held in Miami Beach Convention Hall. Total registration is expected to be about 10,000.

OFFER MICHIGAN REHAB DIRECTORY; WRITE TO MSMS

A directory listing the state's rehabilitation facilities and services for physically impaired persons is available to physicians in Michigan.

The "Directory of Michigan Medical Facilities for the Physically Impaired" was published by the MSMS Committee on Rehabilitation.

Interested MSMS members may obtain a copy by writing the MSMS, 120 W. Saginaw, East Lansing 48823.

Marjorie Peebles Meyers, M.D., Honored As "Outstanding Physician of the Year"

Marjorie H. Peebles Meyers, M.D., Detroit, presented her report to the MSMS House of Delegates, Sunday night, September 22 as chairman of the "Committee to Select MSMS Members for Certificates of Commendation."

The next report caught Doctor Meyers by surprise!

James B. Blodgett, M.D., Speaker of the House, called upon D. Bonta Hiscoe, M.D., Lansing, chairman of the "Committee to Select Michigan's Outstanding Physician of the Year."

Doctor Hiscoe reported that the Committee was recommending an outstanding practitioner, educator, medical statesman and civic leader — Marjorie Peebles Meyers, M.D.!

The Delegates adopted the report unanimously and the award was formally presented to Doctor Meyers at the Delegates Dinner, September 24.

* * *

DOCTOR MEYERS, ACCORDING to Doctor Hiscoe in his Committee report, was selected for many reasons:

— Doctor Meyers is a highly-respected Detroit internist,

— Doctor Meyers is regarded as an excellent Assistant Professor in the WSU Medical School,

— Doctor Meyers is an active member of the Wayne County Medical Society and MSMS,

— Doctor Meyers is one of the MSMS alternate delegates to the AMA House of Delegates,

— Doctor Meyers is a hard-working officer and member of several Michigan and Detroit health, welfare, educational, and cultural organizations,

— Doctor Meyers was selected recently as one of the "Top Ten Detroit Women Who Work,"

— Doctor Meyers, who is married to a minister, holds a responsible lay position in the Episcopal Church in Michigan.

DOCTOR MEYERS DECIDED TO become a physician at age 13. There was nothing traumatic about the decision. "It was a hot, summer's night," she recalls, "and my parents had invited guests over for the evening. One of them asked me what I wanted to be when I grew up and I replied, 'A doctor.' " Fifteen years later she received her medical degree from Wayne State University.

Her childhood was warm, secure and somewhat sheltered. She was an only-child and grew up in Harlem before it became "what it is now." Her father, a special clerk on foreign mail for the Post Office Department, made sure his daughter developed an early interest in education. "I remember his coming home from work, turning the radio on softly and reading to me from the *New York Times*," she said. "It wasn't long before he had me reading the newspaper to him. I learned Shakespeare before I could write."

Not only was young Marjorie exposed to the world of books, she was taught a philosophy of life. "I had no problem with identity or any fear that there would be things I couldn't do. I was taught that a person can do anything provided he has it on the ball."

Although she was aware she was Negro, her environment cushioned her from most discrimination. The neighborhood was integrated and closely allied. People were friendly and took an active interest in the neighborhood youngsters.

Even when she entered Hunter College in New York, her close circle of friends buffered Marjorie from the racism of the outside world. "We were a motley crew," Doctor Meyers says of her schoolmates. "There were six of us who had gone through high school together and enrolled at Hunter. One was French, two were Irish, one was a German and one a Jew. I'm Episcopalian. We

The delegates applauded long and voiced enthusiastic approval for the selection of Doctor Meyers as the "Physician of the Year."

Doctor Meyers expresses her grateful thanks to the House of Delegates for the high honor.

stuck pretty close together. One day an English teacher asked one of the girls, 'Is Marjorie a Negro?' My girl friend replied, 'Gee, I don't know!' "

The light-skinned young lady suspected discrimination when she applied to Columbia Medical School in 1939. She had just completed her Master's program at Columbia. She was told that enrollment in the fall class "was impossible," enrollment the following year, "might be," but that enrollment three years hence, "was assured." She felt Columbia didn't really want her — not because she was Negro but because she was a woman.

DOCTOR MEYERS MARRIED the Rev. Frederick R. Meyers in 1939. He was a vicar in a New York church and the couple met through church work. Shortly after they were married, the Reverend Meyers accepted a call at St. Mathews in Detroit. His wife promptly made application to WSU Medical School. Reverend Meyers now serves as a Canon for the Cathedral Church of St. Paul in Detroit.

It was after admittance to WSU that Doctor Meyers felt the bite of discrimination.

"There were five or six women in our class. One day I noticed, through the mail box windows, white envelopes for all the girls except me. They looked like invitations.

"Without thinking I asked, 'What are all those white things you girls are getting?' The girl I asked looked uneasy, then drew me aside. She had tears in her eyes and told me they were invitations to pledge a sorority, and said, 'Oh Margie, you've been blackballed!' "

"I felt rather uncomfortable at the moment, but it was later that the reaction set in. I became so upset I flunked an exam. The more I thought about it the worse I felt, especially since a medical sorority is supposed to be composed of the cream of the crop. I finally became utterly and extremely ill. I didn't even mention it to my husband for days."

* * *

SHE RECEIVED her WSU medical degree in 1943, and served her internship and residency at Receiving Hospital, Detroit. The late Gordon B. Myers, M.D., former Chief of Medicine at WSU, influenced the young doctor's decision to specialize in internal medicine and serve her internship at Receiving.

Doctor Meyers believes strongly in a one-to-one doctor-patient relationship. "One reason I didn't specialize in Pediatrics is because you have a one-to-three relationship;" she says, "the child and his two parents. I like children, but I'm scared to death of sick children. That's another reason," she quipped.

She and her colleague, Eugene M. Shafarman, M.D., share facilities on the 11th floor of the Professional Plaza in the Detroit Medical Center, a half-block from Harper Hospital.

WITH A SLIGHT TRACE of Eastern accent remaining, Doctor Meyers is outspoken in her concern for a better public relations program for the medical profession, and especially for the American Medical Association. She points out that the profession is undergoing many changes, making many advancements, but that the public is usually not informed or ill-informed. "We never seem willing to admit that we can be wrong or make a mistake," she says. As a result, the public becomes suspicious of many things which are accomplished.

Critical of AMA, Doctor Meyers feels the organization still harbors racial prejudice. "The Na-

Doctor Meyers receives warm congratulations of Brock E. Brush, M.D., chairman of MSMS public relations committee.

tional Medical Association was organized because of the bias in the AMA towards Negro physicians," she charges. "And at the recent meeting in Houston, the AMA didn't even have the courtesy to send a representative.

"I'm a dues-paying member of the American Medical Association because I feel a person should not criticize something unless he also works to change conditions. I guess I'm doing both. And you can quote me on that," she added.

Doctor Meyers believes racial conditions are improving. "As recently as 18 years ago," she says, "there were certain beds designated at some hospitals for Negro patients. Negroes had to wait until a Negro bed was available before they would be admitted. This is no longer the case."

SHE ALSO BELIEVES that there is a severe shortage of Negro physicians, and that neither Negroes nor women are handicapped when pursuing a medical career.

"My advice to anyone who wants to become a doctor is always the same. If the person is a woman I ask, 'Do you plan to use your medical degree?' Women who plan to marry and raise families instead of practicing medicine should not try to become doctors. It's too expensive for both the student and the public which shares the cost.

"If the woman is going into medicine to work with people, she must be reasonably 'solid.' She can't be sensitive and think that people will do things for her simply because she is a woman. One's physical and emotional strength must be rated. But one of the most important requisites is a sense of humor. You must be able to laugh, especially at yourself.

"Finally, you don't look at the color of your skin if you want to be a physician. You look at what you have between your ears . . . and where you can get financing."

* * *

DOCTOR MEYERS IS a dedicated member and leader in many organizations. In addition to the groups named early in this article, Doctor Meyers is vice president of the Michigan United Fund, vice-president of the Detroit Urban League; active in the Neighborhood Service Organization which works with Detroit youngsters; treasurer of Detroit Adventure, a cultural group; a member of the Michigan Society for Mental Health; a board member of Boy's Republic; President-Elect of the Michigan Diabetes Association; a board member of the Michigan Heart Association; a board member of the Rehabilitation Institute; the first and only woman member of the Standing Committee for Advice and Counsel to the Bishop of the Diocese of Michigan of the Episcopal Church, a member of the Detroit Committee on Alcoholism, and a long-time worker for the Detroit YWCA program.

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

U. S. POLIO CASES DROP OFF 99.9 PER CENT

Polio cases throughout the United States were down to 15 during the first seven months of 1967, virtually a 100 per cent drop in incidence since Salk vaccine was first used in 1955.

This represents the lowest national total on record, with only 10 states involved so far.

The Health Insurance Institute, citing United States Public Health Service reports, said 13 of the victims had contracted paralytic polio.

The peak year for the often-crippling disease was 1952, when 57,879 cases were reported. Since then, the Salk vaccine, and the Sabin vaccine, introduced in 1961, have all but eliminated the polio threat in this country. In 1955, 28,985 cases were reported.

AMA-NEA PARTNERSHIP

School health has been a particularly vital concern to the AMA since 1882, when it urged that hygiene be taught in schools. For 56 years the AMA has worked directly with the National Education Association to shape policies and practices in school health education and services.

COMING EVENTS

U-M Reunion Offers MSU Game, Oct. 11-12

One of the special highlights of the annual Medical Center Alumni Society Reunion at Ann Arbor October 11-12 will be the opportunity to cheer for the Wolverines on Saturday, October 12 against the rival Michigan State Spartans.

The two days of activities always include the football game, and 1968 offers the outstanding grid battle.

Special guests will be the 50-year graduates from the 1918 medical and nursing classes. Other alumni especially invited are those whose graduating year ends with a 3 or 8, such as 1923, 1928, 1933, etc.

Speakers will include Robben Fleming, U-M president; Dean of Medicine William N. Hubbard, Jr., M.D., and Dean of Nursing Rhoda R. Russell, R.N.

President of the Medical Center Alumni Society is John O. Goodsell, M.D., Saginaw.

MSMS, U-M PLAN SEMINAR DEC. 1 ON ADOLESCENTS

MSMS, through its Postgraduate Medical Education Committee, will co-sponsor with the University of Michigan Department of Postgraduate Medicine, the 1968 Winter Symposium on "Creativity, Conformity and Concepts of the 20th Century Adolescent," at the Sheraton Ann Arbor Motor Inn, Sunday, December 1. The Symposium will be financed by Geigy Pharmaceuticals, a Division of Geigy Chemical Corporation. Copies of the program may be obtained from the Department of Postgraduate Medicine at the U-M Medical Center.

MEDISCENE

Oct. 9 — Family Life Education Workshop, MSMS Headquarters, East Lansing
Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor
Oct. 20-26 — National Community Health Week
Oct. 23-24 — Michigan Tuberculosis and Respiratory Disease Association Annual Meeting, Hayes Motor Hotel, Jackson
Oct. 24 — Michigan Thoracic Society Annual Meeting, Hayes Motor Hotel, Jackson
Oct. 30-31 — Symposium on Neuroendocrinology of Human Reproduction, McGregor Conference Center, Wayne State University
Nov. 6 — The Council, MSMS Headquarters, East Lansing
Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron
Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit
Dec. 1-4 — AMA Clinical Convention, Miami Beach
Dec. 11-12-13 — 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing
Dec. 18 — The Council, MSMS Headquarters, East Lansing
May 21, 1969 — Annual Muscle Symposium — Wayne County Medical Auditorium, Detroit

WSU Reproduction Seminar, Oct. 30-31

Harper Hospital and the Wayne State University School of Medicine will sponsor a two-day symposium on the "Neuroendocrinology of Human Reproduction" October 30-31, in the WSU McGregor Center.

Specialists will offer biological and clinical perspectives on the physiology and pathology of reproduction. Program chairman is Harold C. Mack, M.D. For further information contact Symposium on Human Reproduction, Wayne State University, 100 West Kirby Avenue, Detroit 48202.

PONTIAC ART SHOW TO BENEFIT RESEARCH

The Research Foundation of the Pontiac Providence Hospital Medical Staff will present its 2nd Annual Art Exhibit at the Adeline Fisher Center, Friday, October 11, from 10:00 a.m. - 5:00 p.m., and Saturday and Sunday, October 12 and 13, from 10:00 a.m. - 10 p.m.

Included will be the work of well known and amateur Michigan artists, displaying oils, water colors and ceramics.

MHC Placement Services Helps Locate 850 Doctors In Michigan in 15 Years

In its 15th year of operation, the M.D. Placement Service of the Michigan Health Council has been responsible in part for the placement of more than 850 doctors of medicine in Michigan. In recent years placements have averaged approximately 55. In the period from July 1, 1967 to June 30, 1968, sixty-two M.D.s were placed.

All of the usual activities in the Placement Service which take place in the first six months of the year have been completed. These include revision of the rosters and a survey of all communities registered with the Service to bring the opportunities up to date. At the same time, all of the M.D.s registered have been contacted to determine if they still wish to receive placement information.

The list of communities needing doctors is ever increasing. More than 140 now are in need of at least one family physician, and over 60 communities are searching for medical specialists. Several communities in need of doctors have developed special brochures under the guidance of, or in cooperation with, the Michigan Health Council. These publications have been distributed to physicians registered with the Placement Service.

In cooperation with the Michigan Tourist Council, a full-page advertisement was placed in the Student AMA Journal, *New Physician*. Response was very good, and the ad was repeated in the publication. We also arranged to have the advertisement placed in *Physician's Management*, a publication that reaches family physicians throughout the United States. The magazine has run the advertisement on numerous occasions as a public service to doctors and to the Council. The ad also has been placed in all of the magazine's specialty publications. More than 300 replies have been received as a result of this national campaign. The first doctor to locate in Michigan as a result of this program is in general practice in Sturgis.

Consumers Power Company, because of its interest in the economic development of rural Michigan and its recognition of the need for an adequate number of doctors, has taken a keen interest in assisting the Michigan Health Council in promoting Michigan as a place to practice medicine. The Company developed an outstanding brochure that describes the vast opportunities for family doctors. Copies are available in quantity to Michigan physicians who are interested in sending the brochure to medical students, interns and residents along with a personal message inviting them to come to Michigan.

The Upjohn Company of Kalamazoo has continued its much appreciated financial support of the Council's Placement Service — which is rated by doctors using it as the most helpful in the Nation.

The Dentist Placement Service continues to grow, and the number of opportunities for dentists throughout the State has tripled in the past two or three years.

HEART, CANCER, STROKE NOW CLAIM 7 OUT OF 10

Heart disease, cancer, and stroke, taken together, claimed 1.2 million American lives in 1965 — about 7 out of every 10 deaths in this country.

Heart disease — or, more technically, the cardiovascular-renal diseases — can be divided into three major categories: (1) strokes — damage to the blood vessels affecting the central nervous system; (2) diseases of the heart and blood vessels serving the body, including rheumatic fever, arteriosclerosis, high blood pressure and hypertensive heart disease; and (3) kidney disease, including chronic nephritis and renal sclerosis. Heart disease and stroke accounted for over 900,000 deaths in 1965.

Uncontrolled cancer growths, which invade and destroy living tissue, occur in a variety of forms in many different body locations. In 1965, cancer caused nearly 300,000 deaths. Unless cancer rates are cut, about one out of every four people alive in the United States today can expect to develop cancer at some time.

— Quoted from
Reference Facts on Health,
Education, and Welfare,
U.S. Department of H.E.W.

ACTIVITIES, PROJECTS

Would Alert Public To Health Hazard Posed by Chiropractors

The AMA House of Delegates in San Francisco adopted a resolution which urged all state and county medical societies to alert the general public to the health hazard posed by the cult of chiropractic. The resolution pointed out that physicians have a direct and personal responsibility to provide the best scientific medical care and to protect the health of the public.

The resolution called attention to the AMA's statement of policy which notes in part that:

> *"It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and rigid adherence to an unscientific approach to disease causation.*
>
> *" . . . The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results."*

The resolution urged state medical associations and component medical societies to adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression.

SMOKING-HEALTH POSTERS AVAILABLE FROM MSMS

Physicians interested in communicating an anti-smoking message to patients can consider displaying a striking poster which reads, "1,000 Doctors Have Quit Smoking Cigarettes (Maybe they know something you don't)."

Posters are available from MSMS Headquarters, P.O. Box 152, East Lansing.

Smoking Council Provides Program Guidance for PTAs

A new program planning guide, designed to help discourage smoking among children, is being distributed in September to the 2,200 local PTA units in Michigan.

The guide was developed by the Michigan Congress of Parents and Teachers in cooperation with the Michigan Council on Smoking and Health.

The suggestions are designed to help PTAs inform the parents of school-age children about the dangers of smoking and to discourage young people from starting to smoke.

The project also seeks to encourage parents to examine their smoking behavior and its possible influence on children, "the great imitators;" to urge parents' support of school programs dealing with smoking and health; and to urge parents to cooperate with local health organizations in solving the problem of smoking.

Mrs. Mary Palmer, of Parma, is health chairman for the Michigan Congress.

The Michigan Council on Smoking and Health consists of 16 member organizations, including the Michigan Congress and the Michigan State Medical Society.

State Physicians On AAP Program

Seven Michigan physicians will participate in the 37th annual meeting of the American Academy of Pediatrics, October 19-24 in Chicago.

Stuart M. Finch, M.D., of Ann Arbor, will serve as chairman of a general session panel, "Sex Education — The Parents' Role," Tuesday, October 22.

Participating in the Monday, October 21, scientific program of the Section on Surgery will be James R. Lloyd, M.D., of Detroit; and Edward S. Tank, M.D., George E. Bacon, M.D., and George H. Lowrey, M.D., all of Ann Arbor. Doctor Lloyd will conduct a session on Gastrointestinal Perforations in the Newborn: Etiology and Management, and the three Ann Arbor doctors will lead a discussion of Surgical Management of Thyrotoxicosis in Children.

Reuben Meyer, M.D., and Allan Done, M.D., both of Detroit, will participate in the annual meeting of the American Association of Poison Control Sessions during the Monday, October 21, session. Doctor Meyer will take part in a program on Dialysis for Toxins, and Doctor Done will participate in a session on Hallucinogenic Drugs.

The Academy's annual meeting includes general sessions, seminars, section meetings, special sessions, clinical conferences, a business meeting and technical exhibits. It will be held at the Palmer House in Chicago.

Pathologists Award Two $500 Fellowships

The trustees of the Michigan Society of Pathologists have approved the donation of two $500 junior college fellowships to Michigan students planning careers in medical technology.

The funds are to be administered by the National Committee for Careers in Medical Technology. The two students so honored this year are Barbara J. Nelson, 5700 Brockway, Saginaw, who has been attending Delta College, and Carol Lynn Shoksnyder, 6525 Merriman, Garden City, who has been attending Schoolcraft College at Livonia.

College Counselors Thank MSMS, Want More AMA Career Books

MSMS has launched a new effort to provide new accurate information to college counselors about careers in medicine and the many health vocations.

Among the MSMS activities in this field has been the distribution recently of copies of the AMA handbook "Opportunities Unlimited" about health careers.

The response from the college counselors has been gratifying.

In part, the reply from Thomas R. Plough, Dean of Students at Alma College, said, "I feel this AMA handbook will be of value in our career information file. Please send me four more copies. Your concern and interest in this matter is greatly appreciated."

"With our growing biological science and premedical curricula it would be most helpful if you could forward 10 copies of your 'Horizons Unlimited' book for interested students. It would be most helpful if other vocational areas could produce such a useful pocket-book as has the medical profession. With your leadership in this field, others might follow," wrote Michael J. Wiener, counselor at Michigan Technological University at Houghton.

"The pocket-book 'Horizons Unlimited' will be of great value to us in our work with young people," wrote Jean M. Phillips, Director of the Northern Michigan University Counseling Center. The letter asked for 10 more copies for interested students.

Flashback to County Programs 50 Years Ago. . .

What were county medical society meetings like back in the period from 1904 to 1924?

What subjects did the scientific meetings deal with?

These questions can be answered, in part, by reading the "Medical History of Muskegon County," written by William M. LeFevre, M.D., of Muskegon. It was back in 1904 that MSMS Councilor William T. Dodge, M.D., traveled from Big Rapids to Muskegon to help the Port City doctors organize a component society. Prior to that, the Muskegon physicians were formed into the Physicians Mutual Aid and Protective Association. There were 47 physicians in Muskegon County in 1904.

Doctor LeFevre examined the records for the first 20 years of organizational activity, 1904 to 1924, and wrote:

"A total of 244 scientific papers were presented before the Society over this period, mostly by the members themselves, but about one-quarter were by outstanding physicians from other parts of Michigan and near-by states.

"Nineteen percent of these papers dealt with surgery and its allied branches, such as fractures, thyroid disease and gynecology. Thyroid disease was considered surgical at that time because no medical management had as yet been introduced.

"Tuberculosis and lung disease were big factors in the everyday practice of the physician and they were the subject of thirteen percent of the papers.

"Infection other than tuberculosis naturally was of great interest and accounted for ten percent of the papers. This section of the medical field was naturally large, due to the many mill accidents and natural traumatic mishaps. Iodine and carbolic acid were the chief antiseptics in general use, but many a case recovered after the generous use both internally and externally, of the next best antiseptic, whiskey.

"So the above mentioned categories accounted for almost half of the scientific papers of this period and the other half included such other subjects as are of paramount importance to the doctor of today such as pediatrics, therapeutics, neurology, laboratory tests and their use, cardiology and many others."

Hope U-M Postgraduate Center Will Be Ready in Early 1969

With the summer construction strikes over, work has resumed on the $2 million postgraduate medicine center on the grounds of the University of Michigan Medical Center in Ann Arbor. Begun in the spring of 1967, the two-level building will hopefully be complete in January or February of 1969.

THE MAIN TEACHING facility in the building will be the 520 person continental-style Dow auditorium. There will also be a 170-seat lecture hall with a stethephonic communications system between each seat. This system will be used in the teaching of cardiology.

In addition there will be three 50-60 seat classrooms and at least two seminar rooms with capacities for 20-30 people. Also a large exhibit and demonstration hall will be a part of the new center, as well as seven overnight rooms for guest faculty members who frequently take part in the continuing education program.

During the 1968-69 academic year, the University will offer slightly more than 40 courses for physicians and other health personnel.

The importance of continuing education for allied health personnel is outlined by Harry A. Towsley, M.D., director of the postgraduate medical education program:

"In this day of the need for supporting personnel in all medical fields, these courses will give them an opportunity for continuing education programs, helping them to help the doctor give patient care."

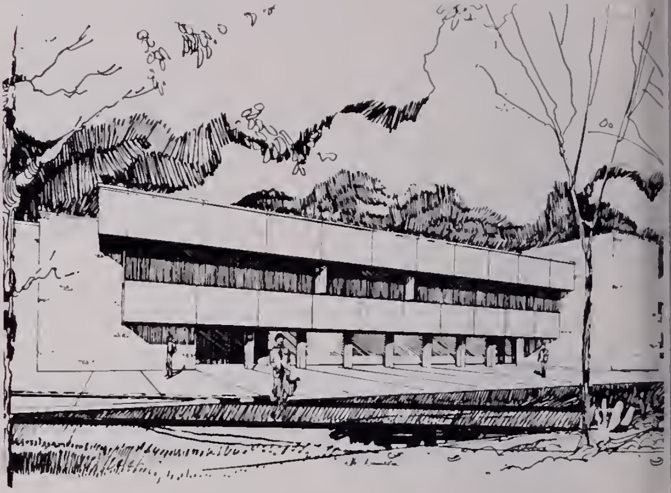
"IN PLANNING THE programs for continuing medical education for physicians," Doctor Towsley says, "every effort has been made by the clinical and teaching members of the faculty to sort from the overwhelming volumes of biomedical literature, that information which is applicable in the day-to-day care of patients."

"We start from where the physician is," he added, "instead of teaching him simply what the researcher wants him to know."

Physician courses are of two kinds at the postgraduate education center: the short, intensive course which runs from 1 to 3 days; and the drive-in course which consists of weekly classes held over a period of many weeks.

THE NEW BUILDING will increase the Potential of the postgraduate medicine program in three basic ways, according to Doctor Towsley:

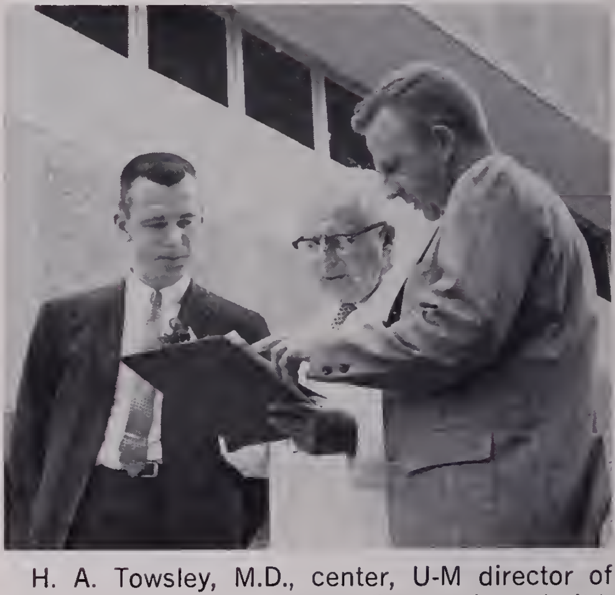
It will permit an expansion of already existing programs and serve as a catalyst for developing new ones.



It will greatly enhance the teaching potential of the post-graduate program because of extensive planning for flexibility in the use of audio-visual aids.

It will serve as a regional meeting place for physicians and other health personnel groups.

Physicians who want further information on the post-graduate programs can write to the Department of Postgraduate Medicine at the University of Michigan Medical School in Ann Arbor.



H. A. Towsley, M.D., center, U-M director of postgraduate medical education, reviews building plans with Ralph E. Lewis, left, and Robert K. Richards, right.

Observations about Health Platforms Adopted by GOP and Dem Conventions:

BY WASHINGTON OFFICE
OF THE AMA

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

THE REPUBLICAN PLATFORM also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of Medicare care," the Democratic platform said.

WITHOUT BEING SPECIFIC, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of Medicare or Medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Donald E. Wood, M.D., Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; John R. Kernodle, M.D., Burlington, N.C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

THE AMA STATEMENT expressed hope that the next federal Administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

The AMA emphasized the desirability of health programs being partnerships among private enterprise and federal, state and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety, and education of physicians and allied health personnel.

CONCERNING HEALTH CARE costs, the AMA said:

"We believe that programs to increase the production of medical and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward a health in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as Secretary, with overall responsibility for all federal health programs, so that maximum effectiveness may be attained.

"We have always maintained that high-quality medical care should be available for all Americans, including those who need assistance in meeting the costs of such care. . . Firmly convinced that adequate health insurance coverage is the choice mechanism for the financing of quality health care costs, we suggest that the country embark on a program of tax credits for health insurance premiums. Under such a plan, all individuals and families would be encouraged to provide themselves with health care cost protection, with those in financial need receiving the greater amount of tax credit on a graduated basis."

SOCIO-ECON

Manufacturing Rising in State

Manufacturing in Michigan, after posting only modest gains for 1967, is on the upswing again.

The Seventh Federal Reserve District, using an index based on industrial consumption of electric power, reports that the state and other centers located within the reserve district show signs of recovering from production decline.

Saginaw, last year, was the only Michigan city to record a production increase greater than the year before. Rapid expansion of capital expenditures by business in 1965 and 1966 produced massive inventories. This resulted in production "adjustments" in 1967. The slump in automobile sales extended the adjustment to consumer durables.

The five states within the district — Illinois, Indiana, Iowa, Wisconsin and Michigan — account for 23 per cent of the nation's manufactured products. Production of durable goods within the district total some 69 per cent of output. Prosperity is strongly influenced by business expenditures for new plant and equipment.

Manufacturing has grown faster in Detroit, Grand Rapids, Jackson, Muskegon and Saginaw

(Continued on Next Page)

Michigan Medicaid Statistics Offered

Effective October 1, 1966, Michigan Blue Shield was selected formally by the Michigan State Department of Social Services to administer certain benefits of the Title XIX (Medicaid) program for the State, and began immediate servicing of the program. Unlike Title XVIII (Medicare), which is financed by Social Security funds and is a national health care program for persons aged 65 or more, Title XIX (Medicaid) is financed in various formulas of matching funds for various health care services for certain categories of people as determined by the various states. Its benefits vary from state to state but generally pay the full cost of medical service.

In Michigan, Title XIX health care is furnished to two groups of persons. Group One, the "Categorically Needy," is composed of persons who receive financial aid under the State "categorical" programs of Aid to the Blind, Old Age Assistance, Aid to Families of Dependent Children and Aid to the Disabled. Group Two, the "Medically Needy," is made up of persons who support themselves without financial assistance in nonemergency circumstances, but who are judged unable to finance certain medical needs. Their eligibility is this state is determined by a formula based upon income, property and other assets, and family size.

In Michigan, Group One, the Categorically Needy, peaked at 243,732 persons in November, 1967. The pool of persons eligible for Group Two, the Medically Needy, is estimated at 375,000. Therefore, Michigan Blue Shield's total responsibility for service under Medicaid involves 625,000 people, or almost as many persons as the total populations of Lansing, Flint, Grand Rapids and Saginaw.

Table 1 gives an account of the number of services and claims paid during the period from October 1966 to December 1967.

TABLE 1

TITLE XIX — PAID CLAIMS AND SERVICES IN MICHIGAN

Paid Period, October, 1966 - December, 1967

Group I	Amounts	% of Total	Number of Services	% of Total	Average Cost Per Service
Old Age Assistance	$ 2,984,979	20.17%	782,070	33.89%	$ 3.82
Aid to Blind	145,882	0.99	25,242	1.09	5.78
ADC Adults	4,105,906	27.74	600,327	26.02	6.84
ADC Children	2,498,705	16.88	348,782	15.12	7.16
Aid to Disabled	2,733,114	18.47	438,556	19.00	6.23
Total Group I	$12,468,586	84.25%	2,194,977	95.12%	$ 5.68
Total Group II	$ 2,330,923	15.75%	112,610	4.88%	$20.70
Total Group I & II	$14,799,509	100.00%	2,307,587	100.00%	$ 6.41

than in the United States as a whole: seven per cent annual growth between 1960-66 compared to six per cent for the nation. The growth is attributed largely to production of automobiles and related equipment.

Michigan produces 40 per cent of the country's motor vehicles and more than a third of the district's production of durable goods. The auto industry, however, is strongly cyclical.

Michigan's production of non-durables, while showing a slower growth rate, exhibits greater growth stability. Food products and chemicals account for more than half of the state's manufacture of non-durable goods. More than 40 per cent of Battle Creek's output is in food products while almost 60 per cent of Kalamazoo's manufacturing is in chemical and paper products.

Although neither city has enjoyed the rate of manufacturing growth experienced in durables, both have shown stable increases of about six per cent per year. ☐

Sees Medical Schools Graduating 10,000 Each Year by 1975

"Today, the United States has a physician population of approximately 300,000. This includes approximately 185,000 physicians who are in private practice; about 55,000 who provide medical service in other than private practice, (as full-time members of hospital service staffs or medical school faculties, in administrative, laboratory or preventive medicine, or in research); and more than 45,000 who are completing hospital internship or residency training. The remaining 15,000 are either retired or not presently practicing medicine."

"By 1975, at least 350,000 physicians will be required to meet the nation's growing needs for physicians, according to the United States Public Health Service. It estimates that physicians will be graduating at the rate of 10,000 a year by then — a rate nearly 2,500 greater than that achieved in the 1965-66 school year when 7,574 physicians (an all-time high) were graduated."

"To provide the additional physicians which are necessary, the nation's medical schools are concentrating on accelerating their already-impressive expansion programs. Approximately 20 new medical schools now are envisioned, including 13 which already are in various stages of development."

—AMA Horizons Unlimited

Forecast Trends In State Economy

The Federal Reserve notes that local interruptions in manufacturing activity have pronounced effects on industrial output. In 1967, the Detroit automobile strike and the summer riot contributed to overall decline in productivity.

On the basis of technical reports prepared by the State Resource Planning Division of the Michigan Department of Commerce, the following observations can be made:

1. Total employment in Michigan is forecast to rise from 2,740,500 in 1960 to 3,960,000 in 1980, an employment growth of 44 percent. On an annual basis, this would constitute an increase of 1.9 percent per year from 1960 to 1980. Thus Michigan's growth would parallel the national rate.

2. Medical and other professional service employment is forecast to rise by 539 thousand or 164 percent from 1960 to 1980.

3. With the exception of apparel manufacturing which is forecast to rise 167 percent, manufacturing employment is expected to grow moderately and in some instances (e.g., food products, textile mill products, lumber and wood products) to experience declines.

4. Michigan will be called upon to turn out more services relative to goods in the 1970's with travel, education, medical and hospital services absorbing more cents to each consumer dollar.

5. Medical and other professional services, public administration, finance, recreation, trade and business services will be the rapidly growing fields of economic opportunity from now to 1980.

6. From 1960 to 1980, employment in medical and other professional services are expected to increase at rates ranging from 147% in the Detroit 7 Area to 198% in the Jackson area.

7. Michigan will grow from 7.8 million in 1960 to 9.9 million persons in 1980 or 26.1 percent according to forecasts prepared under the State Resource Planning Program.

8. With regards to changes in the age composition of the work force, projections indicate an absolute decline in the number of persons available in the labor force in the age groups between 35 and 50 years of age for 1980 as compared with 1960.

For a more complete analysis details may be studied in "Michigan's Future, It's Population and It's Economy," Technical Report Number 10B, State Resource Planning Program, Michigan Department of Commerce.

AUDITOR OFFERS:

Year End Tax Planning

BY KENNETH B. KNOSTMAN, C.P.A.
LANSING

Doctors of Medicine became subject to SELF EMPLOYMENT TAX for years ending on December 31, 1965, and each year thereafter.

The 1968 rate, including Medicare, is 6.4% of $7,800.00 for a maximum tax of $499.20. These rates are currently scheduled to increase progressively to 7.8% by 1987.

ARE YOUR PROFITS particularly high this year? If so, consider the following:

1. Make needed repairs before year end, and deduct the cost.
2. Stock up on routine supplies. (Drugs, tape, bandages, etc.)
3. Delay billing of patients until 1969.
4. Pay year end bonuses before December 31.

(Should you expect 1969 to greatly exceed 1968, then, reverse the above procedures. Remember, tax savings are accomplished by a "level income" — avoid extreme highs and lows.)

* * *

ARE YOU CONSIDERING the purchase of x-ray, or other expensive equipment with a useful life of at least six (6) years? If so, plan the year of your purchase in order to reap the following tax benefits:

1. An extra 20% depreciation can be taken on the first $10,000.00 cost ($20,000.00 on a joint return). This extra deduction of $2,000.00 on a single return ($4,000.00 on a joint return) may be taken regardless of how late in the year the equipment is put into service.

2. The 7% investment credit would also apply to this purchase (8 year useful life required for full benefit — 6 year life would allow 7% credit on 2/3 of your cost). Again, the credit applies no matter how late in the year your purchase is made.

Example: You buy, and put into service, the $10,000.00 machine in December. You may deduct $700.00 DIRECTLY FROM YOUR TAX.

CONTRIBUTIONS OF appreciated property, rather than money, can save tax dollars.

Example: You own a vacant lot that cost you $500.00 in 1950 — current market value of $2,000.00.

(a) If you sell the lot and donate the $2,000.00 to charity, you will have a net deduction of $1,250.00.

($2,000.00 donation, less taxable gain of $750.00. [50% of $1,500 actual gain]).

In the 50% income tax bracket, your tax is cut by $625.00 because of the donation and sale.

(b) By donating the lot to charity, you will reduce your income by $2,000.00, and the increase in value over the 15 year period isn't considered.

Tax is reduced by $1,000 — a saving of $375.00.

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STATE
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Measurement of Quality and Quantity Of Medical Services

ABSTRACT: Alternative methods of measuring quality and quantity of medical services are reviewed and two methods of measurement under development at Michigan Blue Shield are described.

BY GORDON TAAFFE, Ph.D.
MICHIGAN MEDICAL SERVICES

Objectives of medical care are to relieve human suffering and/or to prevent conditions which lead to suffering. Evaluation of the ways and means that these objectives are met is a necessary part of the medical profession. Self evaluations by the medical profession provide standards of care and upgrade medical services generally. Economic pressures resulting from increased demands and rising costs of medical care necessitate efficiency and cost-benefit analyses of the organization, administration, and delivery of medical care. Basic to these evaluations, however, is the measurement of quality and quantity of medical services.

Sidel[1] describes three ways to measure medical care. They are: 1) to test the knowledge and skills of physicians, 2) to judge methods and practices of physicians by reviewing their records or by observing their work, and 3) to evaluate the end result of the physician's effort, the patient. Each method has advantages and disadvantages. Testing the knowledge and skills of the physician is experimentally the most reliable method of measurement of the three described and in a statistical sense, the most valid. The physician's tested knowledge is compared with a vast amount of medical fact and objective assessments of discrepancies between fact and test results can be reliably made. This kind of measurement is common to medical training and later is a part of specialty boards and other certifying agencies. Testing medical students and physicians has reached a high degree of sophistication and no one has much to quarrel with over this method of measurement.

IT DOES NOT NECESSARILY follow, however, that the well-tested physician who tests well will in fact perform better in practice than will the physician who tests poorly. That is to say, training performance does not necessarily predict subsequent on-the-job performance. Good training is a necessary condition for medical practice but it is not a sufficient condition for excellence in medicine. It is not known, for example, whether the well-trained physician will keep up with the advances of his profession, use sound judgment, or in other ways be a "good doctor." While assuring high standards is an admirable characteristic of the medical profession, good training is not a sufficient index of uniform excellence of medical services.

Reviewing the records of a physician by his peers is a common method of measuring quality of hospital care. This method brings into play many qualitative assessments of various medical procedures and practices. The diversity of medical care and the idiosyncrasies among physicians create wide variability of standards of care, a factor which complicates the reviewing process. The fact that the ultimate responsibility for the care of a patient rests with the attending physician permits the establishment of a variety of standards of care rather than a uniform standard. In addition to these weaknesses in measuring quality and quantity of medical services, the review phy-

This is another in a series of Michigan Blue Shield articles on Utilization Review. The author, Dr. Taaffe, is Associate Director of Utilization Review research staff. He has conducted psychological and educational research studies before coming to Blue Shield. He is also an adjunct professor of psychological statistics and research methods at the University of Detroit. Doctor Taaffe is a member of the American Psychological Association and is listed in Who's Who in American Education and in American Men of Science.

—Louis F. Hayes, M.D.,
Vice President,
Medical Affairs Division

sicians are faced with a large volume of cases to review, a condition which often leads to either reviewing in a superficial way or to selecting extremely atypical cases for review.

HOME AND OFFICE medical services, which comprise the bulk of most physician's medical practice, lie entirely outside the pale of utilization review. Gross malpractice may come to the attention of local medical societies but peer review of routine home and office care is noticeable by its absence.

Finally, going to the patient to measure quality and quantity of medical services presents several problems. To have patients appear before a panel of review physicians is impractical except for exceptional cases and asking the patient about the care he received does not often yield reliable information. Patients that expire do not, of course, permit review. Patient review is the least promising way of measuring medical services of the three methods described.

In contrast to the methods of measuring quality and quantity of medical services just described, Blue Shield is developing two methods of measurement. The two methods capitalize on the voluminous data on health care that Blue Shield accumulates. The first method is computer-assisted peer review. Using this method, the computer will identify atypical cases of medical care for review by a panel of physicians. Computer identification of atypical cases will be based on norms of care for particular illnesses and on medical procedures followed in the treatment of the illness. Norms of care with respect to length-of-stay, post-operative length-of-stay, and other similar variables will be derived from records of utilization while procedures typically followed will be based on criterion indices established by the medical profession. For example, distributions of selected characteristics of medical services will be determined and parameters of the distribution computed. Modal frequencies, medians, and arithmetic averages, ranges, and variances of care will be computed. The several quantitative measurements together will define a domain of medical care, for example pneumonia. Quality of care will be evaluated with reference to these normative criteria. Causes for review of a case will be based on cases which fall in the extremes of normative distributions or which have atypical procedures or both. Constraints with respect to age and sex of the patient as well as severity and complications of the illness will be incorporated into the automated reviewing procedure. Blue Shield records of utilization will serve as the primary data for analysis.

For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

WHILE THE COMPUTER-assisted peer review is oriented towards case studies, pattern and profile studies are directed more toward the measurement of quality and quantity of medical care in the community. This second method of measurement under development at Blue Shield will seek to describe characteristic medical utilization in the community. In these studies, profiles of providers and users of medical services will be established in preliminary studies and patterns of characteristic usage will be under continuing analyses. Quality of medical services will be established on a demand-resources basis as well as on quantitative and qualitative characteristics of providers. Profiles for hospitals, for example, will describe the distribution of hospitals in Michigan by community, number of beds, average number of patients, type of hospital, and other similar characteristics. Relevant variables for physician profiles will be such characteristics as training, specialization, type of practice, professional appointments, and so on. Patient characteristics will be age, sex, family structure, insurance benefits, geographic location, and other similar variables. While profile studies will be largely descriptive, pattern studies will seek to link together the patient with his physician and hospital. Characteristic medical utilization will be the objective of the pattern and profile studies.

Evaluation of current allocation of medical resources against demand patterns for those resources may offer economic insights as well as indices of quality of medical care. Pattern and profile studies will be quite varied and should offer comprehensive analyses of medical utilization in Michigan.

Durbin[2] describes quality of medical care as "the method of determining how close observations of care meet prior expectations of care." Blue Shield will establish "prior expectations" on a statistical basis and will review atypical cases professionally. Both Blue Cross and Blue Shield records of utilization will be analyzed. The records represent not only hospital care but also clinic and home and office medical services. These methods of measurement of quality and quantity of medical services appear to be the most appropriate review of medical services for Blue Shield. It goes without saying that these methods of measuring quantity and quality of medical services are dependent upon vast amounts of medical utilization information and on computers with tremendous data processing capabilities. Blue Shield has the utilization information and computers and a research staff is presently attempting to cope with problems of analysis.

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NINE NEW CANCER FILMS OFFERED MD AUDIENCES

Nine new 16 mm color and sound films on cancer are now available free of charge for viewing by physician audiences, the American Cancer Society announced recently.

The films are entitled as follows: "Cancer of the Skin;" "The Diagnosis and Management of Cancer of the Colon and Rectum;" "Cancer in Children;" "Uterine Cancer: Diagnosis and Management;" "Oral Cancer;" "Hormone Therapy for Advanced Cancer;" "Tumors of the Major Salivary Glands;" "Early Diagnosis and Management of Breast Cancer;" and "Cancer of the Stomach."

Groups of physicians who want to view the films can obtain them from their local unit of the American Cancer Society. □

An American Custom

"The Americans of all ages, all conditions and all dispositions constantly form associations. They have not only commercial and manufacturing companies in which all take part but associations of a thousand other kinds, religious, moral, serious, futile, restricted, enormous, or diminutive. The Americans make associations to give entertainments, to found establishments for education, to send missionaries to the antipodes. Wherever at the head of some new undertaking you see the government of France or a man of rank in England, in the United States you will be sure to find an association."

Alexis De Tocqueville
1805-1859

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Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

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Industry, Physicians, Legislators, Others Seeking Solutions to Air Pollution

BY JULIE ORWIG
LANSING

—In 1952 and again in 1962 a thick, impenetrable smog fell over London. The first time, the stifling seige last two weeks, the second only four days. However, the results in both instances proved the same when Mother Nature finally and sympathetically cleared the air — the city had suffered extensive property damage, but more importantly, soaring death rates were reported during these brief periods.

—In New York City, Ernest L. Wynder, M.D. and Dietrich Hoffman, M.D., of the Sloan Kettering Institute revealed the results of a startling experiment. For six weeks the doctors kept a truck, built to act as a human lung, parked in Herald Square. The truck sucked in thousands of cubic feet of air and ran it through filters. At the end of the six weeks the doctors scraped a thick residue from the filters. Reducing this to its chemical components, they put it on the backs of mice. Eventually, 90% of the mice developed cancer.

—In 1961 a poll revealed that in Los Angeles, where the secret of photochemical smog had been discovered, doctors have told over 10,000 patients to leave the area for their own good.

Certainly these are some of the more dramatic examples of the problems presented by air pollution. However, it has taken just such startling revelations and too often disasters to finally awaken man to the fact that he is creating a virtual sewer from the air he breathes.

Edward Edelson and Fred Warshofsky, in their book, *Poisons in the Air,* report "that the history of air pollution is largely a tale of two cities — London, where the air is historically worse than any other place on earth, and where the greatest air pollution disaster ever recorded occurred; and Los Angeles, which introduced the world to a new type of air pollution, then blazed a trail toward cleaning it up."

BUT AIR POLLUTION is no longer simply a historical problem experienced by a few of our largest cities. Air pollution is here and now — in Michigan. And it is everyone's enemy whether he lives in the city or surrounding countryside. And it is a problem to be reckoned with as technology threatens to spew even increased amounts of poison into the atmosphere while urban living cramps greater numbers into smaller areas.

In 1960 statistics gathered by a U.S. Senate committee confirmed that 43 million people lived in cities with "major" air pollution problems. Another 30 million reportedly lived in areas with problems described as "moderate."

The idea that polluted air could cause disease is by no means new. Medical history reports that at one time cholera, smallpox, diptheria, scarlet fever, yellow fever, malaria and even syphilis were all erroneously thought the result of "bad air."

Now medical science is actually beginning to find that our respiratory systems can be greatly effected by polluted air. But the smoke is only beginning to clear on the relationship between pollution and respiratory disease. Most medical authorities will now admit, however, that there is at least some relationship between the two.

MORTALITY AND MORBIDITY rates seem to support this belief. In the "Journal of Environmental Health," Mel Weisburg, M.D., of the American Medical Association, reports that lung cancer mortality is twice as high in cities as in rural areas, more or less proportionate to the size of the corresponding population. Death rate sta-

Photo, Courtesy of Michigan Department of Public Health

tistics from London; Donora, Penn., and the Meuse Valley in Belgium, where smog disasters have occurred, add further evidence that polluted air is detrimental to the respiratory system.

The extent to which air pollution affects respiratory disease is unknown. One thing is certain, however. Both pollution and this type of disease are on the rise. Just how proportionately the two are related is the dilemma of physicians, government officials, concerned citizens — all those who are attempting to do something to clean up the mess.

OFFICIALS ARE NOT dealing with a disease such as malaria, now known to be caused by five or more species of parasitic protozoa and transferred to the human blood by mosquitoes. The exact causes of asthma, chronic bronchitis, emphysema and lung cancer are unknown.

Government officials find it difficult to move in, as in the case of malaria, and tell a man to clean up the swamp behind his home because it is a breeding place for malaria carrying mosquitoes. With respiratory disease it is not easy to force industry and individual citizens to install emission devices or to stop burning rubbish. The burden of proof lies with the scientist and researcher.

The old adage of "man or mouse" further complicates the case for science. It is virtually impossible to reproduce in the laboratory with any degree of certainty, the gradual effects which an ever-changing polluted atmosphere may have on a human being. Researchers are constantly reminded of the dangers involved in assuming a similarity between human and animal reactions to an experiment.

Much is also being done outside the researchers laboratory to further the cause of clean air. On the national scene the federal government passed the Clean Air Act (88-206) in 1963 which provided for federal grants amounting to $95 million to match local expenditures aimed at the control of air pollution. This contribution has been increased when two or more cities or states join forces in combatting pollution.

In 1965 an amendment (89-272) was passed giving the Secretary of Health, Education and Welfare the power to set emission standards for automobiles and trucks. Providing for the construction of needed research facilities, a total of $92 million over four years was authorized for studies of the problems of waste disposal.

As a result of this amendment newly installed devices on 1968 model cars will reduce hydrocarbon emissions by 60% and carbon monoxide emissions by 50%.

The federal House and Senate this year passed S-780, known as the Air Quality Act which authorizes $428 million over three years to continue and expand efforts of the earlier acts. Under this law states will be given the upperhand in abating air pollution with the federal government stepping in only if their efforts should fail. The law authorizes a two-year study of national pollution standards and will permit states to set their own goals in this area. The Secretary of Health, Education and Welfare is given the power to establish air quality regions and set up commissions to govern regions where air pollution overlaps two or more states or areas.

IN MICHIGAN, THE state legislators are protecting their authority from federal government intervention while at the same time helping to clean up Michigan air through the enactment of new laws.

In 1965 Acts 348 and 250 were passed by the 73rd Legislature. Act 348, known as the Air Pollution Control Act, provides for the creation of an Air Pollution Control Commission within the Department of Public Health. Under this act, the Commission is licensed to promulgate rules and regulations to control air pollution, to compel witnesses in complaint cases to attend hearings, to institute court proceedings against offenders and to provide inspection and approval of air cleaning devices. Act 348 was amended this year to provide that nothing in its content be inconsistent with federal regulations on motor vehicles.

On February 3, 1967, the federal Control Commission adopted a set of rules and regulations to be applied when a written complaint is filed with the Commission against a possible polluter.

Act 250, also passed in 1965, provides that industries may make application with the state tax commission for exemption from real, property, use and sales taxes on air pollution control facilities which they install. The procedures for obtaining such exemptions were further clarified in an amendment (Act 145) passed by the 74th Legislature.

THE LAWMAKERS ARE not the only people in Michigan who are helping to solve the problems of contaminated air. As the spokesman for and protector of the interests of industry, the Michigan State Chamber of Commerce in a recent report applauds the advances being made in correcting pollution.

The Michigan State Chamber, having sold legislators on the idea that incentives would produce better results than punitive measures, was instrumental in promoting the passage of the state act of 1965 which allows for tax exemptions for industrial installation of pollution control devices.

While it is hard to condone industry's reluctance to install air pollution abatement and control devices, still it is understandable. An investment in such facilities does not increase productivity and it does raise the cost of manufacturing.

Industrial agencies are beginning to accept their responsibilities in this area, however. Harold E. Thayer, Chairman of the National Association of Manufacturers Area Industrial Problems Committee, speaking at the National Conference on Air Pollution last December, reaffirmed the contention that industry needs economic incentives, in the form of tax credits, for the installation of pollution control facilities.

As easy as it is to find a whipping boy, industry alone is not responsible for the condition of today's air. Individual refuse burning, smoke from salvage operations and the automobile contribute their share to pollution.

IN THE CASE OF the automobile, the new 1968 exhaust-control additions will help the problem. More research and development are necessary.

On a positive note, Jay A. Bolt, professor of mechanical engineering at the University of Michigan whose present research deals with engines and air pollution, states that present gasoline-powered automotive engines can, at increased cost to the consumer, be further developed to meet any reasonable anti-pollution emission standards.

The Michigan Association of the Professions is concerned too about air pollution. The 1963 Congress of the Professions adopted a resolution which declared, "that MAP directly and in cooperation with its state organization members, support the passage of any necessary legislation to permit the health authorities of Michigan to rid the state of pollution in the air insofar as that can be accomplished by state authority and also that MAP join with other groups, of like policy, in programs of public education in the support of anti-air-pollution efforts."

The MAP resolution declared, in part, that "one of the greatest health menaces facing the people

of Michigan and particularly the residents of Michigan cities is polluted air." The resolution urged preventive action programs in the interest of better health.

It is apparent that industry, researchers, lawmakers and independent community groups are all beginning to take an active part in helping to clean up the air pollution mess.

BUT WHERE DOES the medical profession's responsibility lie in this area?

Ultimately, if air pollution is not controlled, doctors, by virtue of their profession, will have to accept responsibility in caring for the millions of people who will be affected. Hopefully, there will be no more London disasters.

The American Medical Association is taking an active role in the fight. Believing that air pollution is primarily a problem best solved at local levels, the AMA has done much to encourage and support local medical participation in community control activities. For example, the AMA added its support to the Los Angeles County Medical Association's efforts in assisting local authorities in setting up emergency alert levels for pollution and in supporting legislation dealing with auto exhaust and fuel oil burning.

Another function of the AMA is to provide liaison with public and private groups to represent the profession's interests in air pollution disputes. AMA committees have been largely responsible for the preparation of informational documents and statements on air pollution for medical, technical and lay groups.

THE AMA BOARD of Trustees in April, 1965, approved creation of the Joint American Institute of Architects-American Medical Association Committee on Environmental Health. It is hoped that through this committee environmental problems such as air pollution will be more effectively approached through architectural design and planning.

The Michigan State Medical Society House of Delegates has resolved to support and commend the state legislature for their passage of pollution acts 250 and 348.

California, Illinois and New York medical societies have all formerly adopted air pollution programs.

The ills of dirty air can only be cured through individual concern and participation — and this includes the concern and participation of Michigan's physcians.

The AMA's "Physicians Guide to Air Pollution" states, "The physician who advises patients to move on account of air pollution also has an interest in promoting air pollution control in his community. He has a stake in securing purity of air in the same way he has in other biological needs — food, drugs, water. While the control of air pollution may appear beyond the scope of his practice, the physician can contribute medical standards and informed leadership to the community effort."

MSMS PRESIDENT URGES DOCTORS BE INVOLVED IN ANTI-POLLUTION

"The most effective approach to air pollution problems is the grass-roots, community approach."

So declared MSMS President B. M. Harris in a recent editorial in *Michigan Medicine*. He wrote:

"As physicians we have a community responsibility both individually and collectively through our professional and civic organizations to accept the challenge of helping clean the air we breathe."

Doctor Harris urged every MSMS member "to familiarize himself with his community's regulations on air pollution and their enforcement."

The MSMS President also wrote, "The medical fraternity, the ultimate recipients of victims whose exposure has progressed to the symptomatic stage (at which point the only help may be palliative) has both the opportunity and responsibility to participate actively in programs now underway and to eliminate the various sources."

The individual physician in his practice is concerned about the possible effects of pollution on his patients as he studies air pollution data published by local and other government agencies. And more and more doctors are taking an active part in efforts to clean up the present condition of the air.

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Blue Shield Data Processing Nears 150,000 Inputs Daily

Michigan Blue Cross "went computer" in 1955, when it installed an IBM 705 to handle all data processing for itself and Michigan Blue Shield.

Blue Shield's own Data Processing Department came into existence shortly before the advent of Medicare in 1966. It has grown from an original four employees, who coordinated Blue Shield business with the Blue Cross Data Processing Center, to 264 employees involved in a completely separate and independent computer operation.

In June, 1966, Blue Shield took delivery of its first computer, an H200. Its computer staff grew to 78 trained specialists by October of that year, when the computer was transferred to the 17th floor of the Cadillac Tower Building.

Further expansion of the operation occurred when Blue Shield assumed administrative responsibility for Medicaid in December of 1966, and in the spring of 1967 the company began to computerize regular Blue Shield business. At this point the writing of statistical reports and check-writing formerly done by Blue Cross were phased into the operation and 40 more keypunchers added to the staff.

Blue Shield Data Processing came to maturity in August, 1967, as a formally organized Group, complete with Planning & Control, Systems, Programming, Data Control, and Computer Operations departments. Today, the only joint work done between the Blues' two operations is the checking of Blue Shield's daily input against Unifile's enrollment information, and billing.

Low volume programs such as CHAMPUS are processed on keypunch cards. Programs as vast as MEDICARE are computerized. Eventually, all Blue Shield, Medicare and Medicaid pricing will be done by computer.

The use of Data Recorders not only saves 34% in operations expense for data conversion but results in greater speed in processing information, since the computers can read magnetic tape 60 times faster than cards.

Blue Shield's Computer Room, equipped with two H2200 computers with 65K (a tape-oriented system), plus the original H200 computer, handled a volume of 146,000 "inputs" daily during March of 1968, or 81,000 more daily inputs than during the same month in 1967. In addition, by means of a Digitronics Remote Terminal, a machine tied by direct line to Social Security Administration headquarters in Baltimore, Blue Shield transmits and receives Medicare information directly on magnetic tape.

At work in Blue Shield computer operation are Fred Hasson, Nick Kristo and Gary Chick.

While Blue Shield Data Processing is completely modern, plans are already being made for years ahead.

A utilization file of six million case histories is undergoing long term review by MBS to determine what medical services are being used, and how. Such case histories, properly authorized for use, may in the future furnish valuable emergency information about the past ailments, medications and doctors of a patient in a coma.

At this moment Data Processing is gearing to handle an estimated 383,000 inputs daily by 1975, including data concerning the prescription and dental services which are sure to come. This is one more aspect of a progressive modern company with an eye to future, as well as present needs. ☐

Many Colombian men and women, seeking help for themselves and their children, crowd at the docks when the Ship Hope docks to provide medical care.

Enteritis, Gastritis Among Leading Causes Of Death in Colombia

This article describes some of the experiences by Mary L. Cretens, M.D., Gladstone, during a two month rotation, while the Ship Hope was in Colombia. Doctor Cretens is director of the Delta County Department of Health.

My two-month Rotation on the Ship Hope at Cartagena, Colombia, provided an opportunity to observe a kaleidoscopic picture of several decades of medicine. Some areas of medical care were many years behind our own and others were more current. Many Colombian physicians were very receptive to new ideas, some not. It was revealing to see yourself and your reactions reflected in many of the local medics.

Improvisations were important and generally we lacked much talent in this field, although the Colombians were no better. The Colombians were used to letting repairs of equipment and housing go until the equipment or housing was no longer useable, then they would discard it, often with no replacements.

I was somewhat prejudiced, but I felt the Public Health — General Practice Rotation was the best. All physicians had duties both on and off ship, but the two above mentioned had more functions on land. As I had a combination General Practice-Public Health Rotation, I had ample opportunity to observe sick and well people alike. I was priviledged to visit all the health and sanitation facilities of the area. I worked in the Ship hospital and sick bay, the city hospital, the outpatient clinics, and even made home visits and treated patients in their homes. I had a variety of interpreters which learned from me and my predecessors much about medical counseling. They all promised to carry on the continuing land based program sponsored by the Hope. This program will offer service for several years in Colombia. The interpreters were very intelligent women, many from influential families, that could put their finger on the source or cause of health problems. Their interpreter work had drawn them closer to all the people in this two-class society.

The feelings of a true medical-speciality team soon developed among the Rotators and was fostered by quarters so small that if the beds were placed side by side, instead of stacked, there would be no room for walking through the room. The team spirit was helped further by the fine, large, well set tables in the dining room and the group "deck" sessions in the evening. Age of the practitioner made no difference, in fact the most active practitioner on our Rotation was the oldest.

Colombia is a very rich country in resources. Poor distribution of goods and lack of development has prevented the masses from having adequate food and housing (average annual income is $175.-00). There is an extremely high birth rate and 50% of the children are under 15.

The father most often claims little family responsibility for his children, so very few children are educated. This inadequacy of education leads to the crux of their health problems. For example, there is no conception of proper diet. Sweets, fat, and starch are often eaten almost exclusive of other foods. Lack of potable water, coupled with lack of knowledge of cleanliness, plus tropic heat makes for nearly 100% infestation with amoeba, ascaris and the like.

People often do not even know how to get medical help and when they do seek medical help, they must sometimes wait two days to be seen. The

MARY L. CRETENS, M.D.
GLADSTONE

serious cases are not sorted from the insignificant diseases and so the serious problems are not given priority. Often people will not seek the physician's help at all; they will only go to the druggist who dispenses everything but narcotics.

Important causes of death are enteritis and gastritis. Heart disease is relegated to the number four cause of death. One poor lady counted and saved 420 worms her one year old child had passed, but she never considered seeking medical help for the child until we visited her home.

Generally diseases were much the same as elsewhere, except for incidence and severity. Almost all diseases were complicated by malnutrition and anemia. For the physician interested in epidemiology there are many interesting areas; for example, great incidence of enlarged thyroids in a seacoast living people, and the reversion in adults of blood cell patterns similar to those of childhood.

The greatest challenge and opportunity to the Rotator comes in teaching or, as I like to see it, the exchange of ideas. Much can be done by making comparison of methods and arriving at possible alternatives to solve problems.

What is needed in a country such as Colombia is better education at all age levels and the training of more medical and especially paramedical personnel and retraining old personnel in new methods of prevention, diagnosis, and treatment. Generally the Hope is doing just that, so it continues to have lasting value as contrasted to most of our other foreign programs.

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING AUGUST 31, 1968

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	11	22	264	919
Whooping Cough	37	99	321	744
Diphtheria	0	0	0	1
Mumps	108	179	13118	12963
Scarlet Fever & Strep Sore Throat	252	356	7293	9828
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	1	0	1
Hepatitis	167	135	1423	1310
Salmonellosis (Other than S. typhi)	56	44	455	356
Typhoid Fever (S. typhi)	0	0	0	6
Shigellosis	20	19	174	300
Aseptic Meningitis	17	7	54	38
Encephalitis	4	2	56	83
Meningococcic Meningitis	5	3	68	53
Influenzal Meningitis	1	7	37	41
Tuberculosis	218	240	1891	2001
Syphilis	373	413	3671	3820
Gonorrhea	1546	1279	11888	11220

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

State Appellate Court Ruled Hospital Records Admissible in Estate Suit

(Editor's Note: The following article is quoted from the AMA Citation newsletter of August 1, 1968, prepared by the AMA Law Department.)

In a proceeding to determine the validity of a will executed by a testator in a hospital a short while before his death, his hospital records were properly admitted in evidence on the issue of his mental competency. The records met the requirements of the Business Records Act, a Michigan appellate court ruled. An internist's testimony on the testator's competency was also properly admitted.

A hospital employee who was the custodian of records identified the records offered in evidence as those of the patient. He testified that the entries were made in the regular course of the hospital's business and that they were made at or near the time the will was executed. He also testified that the records, including the nurses' notes, were used by the physician in the course of the patient's treatment. The physician who treated the man also testified as to the hospital's procedures in keeping patients' records. He further testified that the observations of nurses and others were of particular importance in this case because the patient was suffering from acute cirrhosis of the liver. There were 15 nurses, as well as numerous laboratory and X-ray technicians associated with the patient's treatment. To have required the calling of each of those persons would not have served any useful purpose, since the records' reliability had been established.

The will's proponent objected to the internist's testimony as to the testator's competency on the ground that his opinion was based solely on the hospital records. However, the evidence showed that he had examined the testator a short time before he was admitted to the hospital. The internist was eminently qualified in his field and was Board-certified. He testified as to the significance of the laboratory data and the administration of drugs appearing in the hospital records, and of the extreme importance of the nurses' notes. He testified that, in a case of cirrhosis such as the testator's, he was particularly concerned about mental confusion as an early indication of the worsening of the patient's condition. He related the mental confusion to the level of blood ammonia which appeared in the laboratory reports and demonstrated that there was a progressive deterioration of the testator's condition. It would have been error to exclude the internist's testimony.—*In re Estate of Searchill,* 157 N.W.2d 788 (Mich., March 20, 1968)

Must Get Consent

BY THE AMA

Is it proper for a physician to discuss his patient's medical condition, disease or illness with the press?

According to the AMA Judicial Council's opinion adopted in November, 1967, a physician's obligation is to his patient.

However, a patient, by virtue of his position, may have an obligation to others such as stockholders or voters to whom he may be responsible. If such an obligation exists, the disclosure of health knowledge must come from the patient, not the physician. The physician should insure the medical accuracy of any authorized report.

In summary, it is the opinion of the Judicial Council that a physician may not discuss the patient's health condition with the press or the public without the patient's consent or, in the event of his incapacity, the family's consent.

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MICHIGAN MEDICINE

Public Seen Accepting Fallacies About Old Age, and Believing Them; Rules for Good Health Suggested

BY PETER HOHEISEL
DETROIT

The shaking hand, tottering gait, loss of memory and mental faculties — are these the necessary consequences of old age?

Are old people necessarily more susceptible to cancer, stroke, and heart disease?

Does age 65 mark the beginning of inevitable physical and mental deterioration?

An emphatic "no" is the answer to all these questions according to the results of 10 years' work by the American Medical Association's Committee on Aging.

"The sad reality is that the American public accepts certain fallacies about old age and lives by them," says Frederick C. Swartz, M.D., a Lansing physician who heads the AMA Committee on Aging. "People think that at 65 they've over the hill and then they give up. Of course that's nonsense."

THE MAIN CONCLUSION of the AMA Committee on Aging study, as expounded by Doctor Swartz, is that there is no disease entity or physical or mental condition that results from the passage of time.

"Age does no damage to any organ," explains Doctor Swartz. "It's the use you put it to that counts. Nor does age make you more susceptible to any specific disease, he continued. I tell patients who are over 30 and complaining about getting old that what they need is conditioning; that they're getting lazy," says the Lansing physician.

"Most people do not really use their muscles, and yet vigorous physical stress is necessary for normal body functioning," he continued. "In order for exercise to be effective, it has to stretch the muscle to the fullest.

"Osteoporosis, a common complaint of older people, is as preventable as polio if people would exercise and stretch their muscles and bones. Lack of exercise is also the fundamental reason behind the many fractured bones and hips in older people."

TO PREVENT SENILITY, Doctor Swartz recommends mental as well as physical exercise. "People should read something hard each day so that their mind has to work. The old saying holds true: 'What you don't use, you lose.'

"These are some of the things people can do," concludes Doctor Swartz, "so that they can live longer, feel better, and enjoy living."

ANOTHER MAN ACTIVE in working with old people is Hazen Price, M.D., chairman of the Michigan State Medical Society Committee on Aging. Doctor Price is medical director for 500 elderly people at the Arnold Home for the Aged in Detroit.

The MSMS Committee on Aging works closely with the Michigan Society of Gerontology in

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Peter Hoheisel is now a full-time graduate student at Wayne State University, after leaving the MSMS public relations staff in September.

physican-education programs so that doctors can know more about the environmental realities which affect an older person's health.

"For a long time physicians weren't interested in things like family situation, housing, and retirement when they treated old people," Doctor Price says. "Now we are encouraging physicians to look into these things for the total care of the individual person.

"We can't take care of a person only in respect to his heart disease; we must take a multidisciplinary approach, and the work of our Michigan State Medical Society committee has been to broaden the outlook and interest of physicians in this field.

"I would like old people to realize that even if they have a chronic disease there is always something that can be done about it, if only to make the person more comfortable with it."

WHAT ARE THE RULES for good health among older people? Doctor Price outlines three basic ones:

1) *Physical activity.* This helps the breathing, circulation, and digestion.

2) *Mental activity.* A person shouldn't think that he can't learn as he gets older.

3) *Useful work.* Inactivity breeds a lot of trouble.

With regard to useful work, Doctor Price believes that older people shouldn't just work to keep themselves occupied, but should be active in being useful to others. "When you lose your usefulness you become a fixture, not somebody important. There is nothing so rewarding as doing something for someone else."

When asked about successful adjustment to old age among the people he knows, Doctor Price replied that the key is in accepting the limitations of old age. "Those who don't accept the limitations are depressed, and never successfully adjust. Instead of doing what they can do, they brood about what they can't do."

Women, according to Doctor Price, adjust to old age better than men. He feels that this is because a woman's life has centered around the home, and with age her life style does not drastically change. Retirement for a man, however, is a radical change from what he has been doing.

THE CONCLUSION OF these Michigan experts on aging is that environment, heredity, and living habits are the main causes of the illness and deterioration, normally associated with old age, and that age 65 is no automatic sign of senility. ☐

Press Promotes Need for Doctors

Every week, Michigan newspapers voice their editorial opinions about various medical and health subjects.

Often these editorials deal with the need for physicians and often they describe efforts of the medical profession to recruit toward this same common goal.

GIFTED YOUNG PERSONS NEEDED

From The Mt. Pleasant Times-News

"There is something very special about a good doctor. In these days when so much emphasis is put on the common man and equality the instinct of survival dictates that when we get sick, we want no part of the common man.

"We want an uncommonly good doctor and good doctors are not created overnight. Moreover, it takes a person of certain aptitude and qualifications to make a good doctor.

"To hear some of the talk about how to increase the physician population, one would think that all that is necessary is to open the doors of the medical schools and herd the young people in for training.

"WHEN IT COMES to the disciplines of science, the good doctor enjoys a happy combination of a penetrating scientific mind and a compassionate consideration for his fellowman—attributes beyond the average person.

"Expanding the doctor population cannot be accomplished as rapidly as laws can be passed that create demand for medical services.

"The American Medical Association at its last annual meeting laid heavy stress on expanding medical school facilities and increasing the output of qualified medical practitioners. ". . . our resolve," states the AMA Board of Trustees, "should always be as it is now; to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated, and highly skilled physicians."

"GIFTED YOUNG PERSONS of ability will find a life of work in the medical arts highly rewarding, spiritually and materially.

"Those who enter this field should dedicate themselves to maintaining the high standards that the profession has established."

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Magnus H. Agustsson, M.D., 2025 W. Holmes Road, Lansing 48910

Henry A. Archambault, M.D., 35550 Michigan Ave., Wayne 48184

Juan Belamaric, M.D., 1400 Chrysler Expwy., Detroit 48207

You Chen Chen, M.D., Children's Hospital, Detroit 48202

Ilhan Conklu, M.D., 401 W. Greenlawn, Lansing 48910

Daniel Cowan, M.D., Dept. of Pathology, MSU, Col. of Human Med., East Lansing 48823

Jorge H. Day, M.D., 11204 Glenfield, Detroit 48213

Leonard E. Ellison, M.D., 3800 Woodward Ave., Detroit 48201

Jerry S. Fagelman, M.D., 27841 Adler, Warren 48093

Richard F. Freeman, M.D., 525 Visger, Ecorse 48229

Raouf R. Hawash, M.D., 25701 Joy Road, Dearborn Heights 48127

Howard C. Hoffman, M.D., 612 First Street, Jackson 49203

Lawrence D. Hoffman, M.D., 20150 Audrey, Detroit 48235

Claudio M. Iacobelli, M.D., 22745 Kelly Road, East Detroit 48021

George A. Kling, M.D., Harper Hospital, Detroit 48201

Alfred M. Kreindler, M.D., 200 Elm Street, Birmingham 48008

Nasi D. Lessani, M.D., 36180 Five Mile Road, Livonia 48154

Melvin A. Lester, M.D., 26831 Woodward Ave., Huntington Woods 48070

William F. Malarney, M.D., 880 Woodward Avenue #106, Pontiac 48053

Edo V. Marcuz, M.D., 11255 Hall Road, Utica 48087

Milton Margoles, M.D., Newberry State Hospital, Newberry 49868

Sue Ann McCutcheon, M.D., Henry Ford Hospital, Detroit 48202

Moufid Mitri, M.D., VA Hospital, Dearborn 48121

Eliezer Monge-St. Laurent, M.D., 23607 Farmington Road, Farmington 48024

Rene Perez-Teran, M.D., 3033 Carpenter, Detroit 48212

Lawrence D. Pipe, M.D., Leila Hospital, Battle Creek 49014

Gordon R. Rady, M.D., 206 N. Heisterman St., Bad Axe 48413

Daleep S. Rao, M.D., 1207 N. Ballenger Highway, Flint 48504

Carl A. Rasimas, M.D., 1210 Kales Bldg., Detroit 48226

Richard C. Relken, M.D., 2920 Pine Grove, Port Huron 48060

Merle F. Rydesky, M.D., 16001 West Nine Mile Road, Southfield 48075

Enrique E. Signori, M.D., 29901 Ford Road, Garden City 48135

Willis H. Stephens, Jr., M.D., 602 N. Woodward Ave., Birmingham 48011

Jose S. Tandoc, M.D., 36200 Plymouth Road, Livonia 48150

Hratch Vartanian, M.D., 6246 Chase Road, Dearborn 48126

Rodolfo Yapchai, M.D., 1846 David Whitney Bldg., Detroit 48226

Thomas G. Schwaderer, M.D., 500 Cherry Street, S.E., Grand Rapids 49503

Miguel A. Casas, M.D., 9613 East Outer Drive, Detroit 48213

Rodger L. Johnson, M.D., 15001 West Eight Mile Road, Detroit 48235

Fred Averbuch, Maj, M.C., USAF Hospital APO, San Francisco 96323

Maximino J. Blanco, M.D., Pontiac State Hospital, Pontiac 48053

John S. Dunn, M.D., 368 Ridgemont, Grosse Pointe Farms 48236

Robert S. Levine, M.D., 900 Woodward Ave., Pontiac 48053

IN MEMORIAM

A. G. Armstrong, M.D., Detroit

A. Gordon Armstrong, M.D., Detroit physician for 43 years, died August 21 at the age of 71.

Doctor Armstrong was a member of staff at Hutzel Hospital and previously at Providence Hospital, Detroit.

Born in Ontario, Canada, he was graduated from the University of Toronto medical school in 1921. He served with the British Navy during World War I.

He was a 33rd Degree Mason and a member of the Detroit Athletic Club.

R. L. Fox, M.D., Traverse City

Richard L. Fox, M.D., Traverse City internist, died September 1, 1968. He was 36.

Doctor Fox was killed in an auto accident.

Doctor Fox received the B. S. degree from the University of Michigan and the M.D. degree from Northwestern University Medical School in 1958. Internship was at Henry Ford Hospital, Detroit, 1958-59. His residency was also done at Henry Ford Hospital, from 1959 through 1962. In 1962 he became a clinical cancer research fellow at the Detroit Institute of Cancer Research.

His practice was primarily in oncology. Hospital affiliations were with Munson Medical Center, Traverse City, and Mercy Hospital, Cadillac.

He was a member of Alpha Kappa Kappa.

L. B. Saraf, M.D., Detroit

Leo B. Saraf, M.D., Detroit surgeon, died June 28. He was 52.

Born in Sungurla in Asia Minor, Doctor Saraf received the A.B. degree from Wayne State University and the M.D. degree from Wayne State University School of Medicine in 1943. His internship was served at St. Mary's Hospital, now Detroit Memorial Hospital, and his residency at Detroit Receiving Hospital. He received formal postgraduate training in pathology at Wayne State University School of Medicine in 1943-44.

Doctor Saraf entered the private practice of general surgery in 1951. He was affiliated with St. Joseph Mercy, St. John, Receiving, Jennings and Detroit Memorial hospitals, Detroit.

He was a member of the American College of Surgeons.

Thomas Schrier, M.D., Comstock

Thomas Schrier, M.D., Comstock general practitioner, died September 6 at the age of 63.

He was affiliated with Borgess Hospital and Bronson Hospital in Kalamazoo.

Doctor Schrier received his premedical education at Kalamazoo College, Kalamazoo. He was graduated from the University of Michigan Medical School in 1931. During World War II, he served in the U. S. Army Medical Corps.

His medical fraternity was Theta Kappa Psi.

K. S. von Haitinger, M.D. Grosse Isle

Kalman S. von Haitinger, M.D., Grosse Isle psychiatrist, died in August. He was 61.

Doctor Haitinger was graduated in 1934 from the University of Louisville Medical School, Louisville, Kentucky. He received the A. B. degree from Tusculum College, Greeneville, Tennessee.

He began practice in Michigan in 1939. From 1942-46 he served in the U. S. Army Medical Corps.

He was a member of the American Psychiatric Association and of Alpha Kappa Kappa.

FOR YOUR PATIENTS:

Today's Health Guide is an up-to-date, 640-page, family health reference that should be in every home. The AMA's long awaited new book, Today's Health Guide, is the product of 200 of the world's most renowned authorities in medicine, science and allied fields.

The Guide discusses more than 2,000 illnesses, diseases and other medical subjects including diet and nutrition, child care, safety and first aid, sex education, mental health and when to seek professional medical attention. Over 300 striking illustrations and an eight-page full-color transparency of the human body vividly complement the text.

Today's Health Guide is the medical profession's answer to the need for an inexpensive yet authoritative and comprehensive home health guide.

Your patients may obtain one by sending a check or money order for $5.95 for each copy to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.

Roerig Rx

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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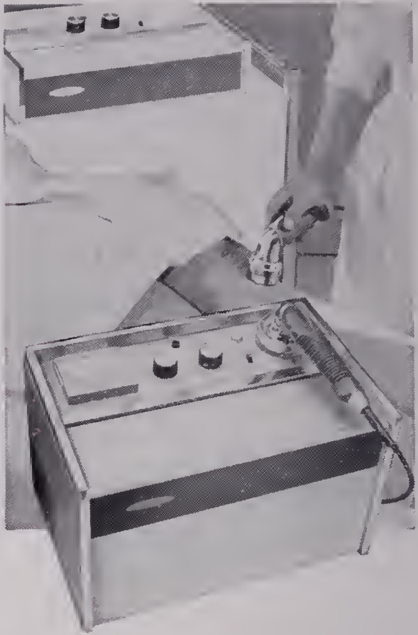

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Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

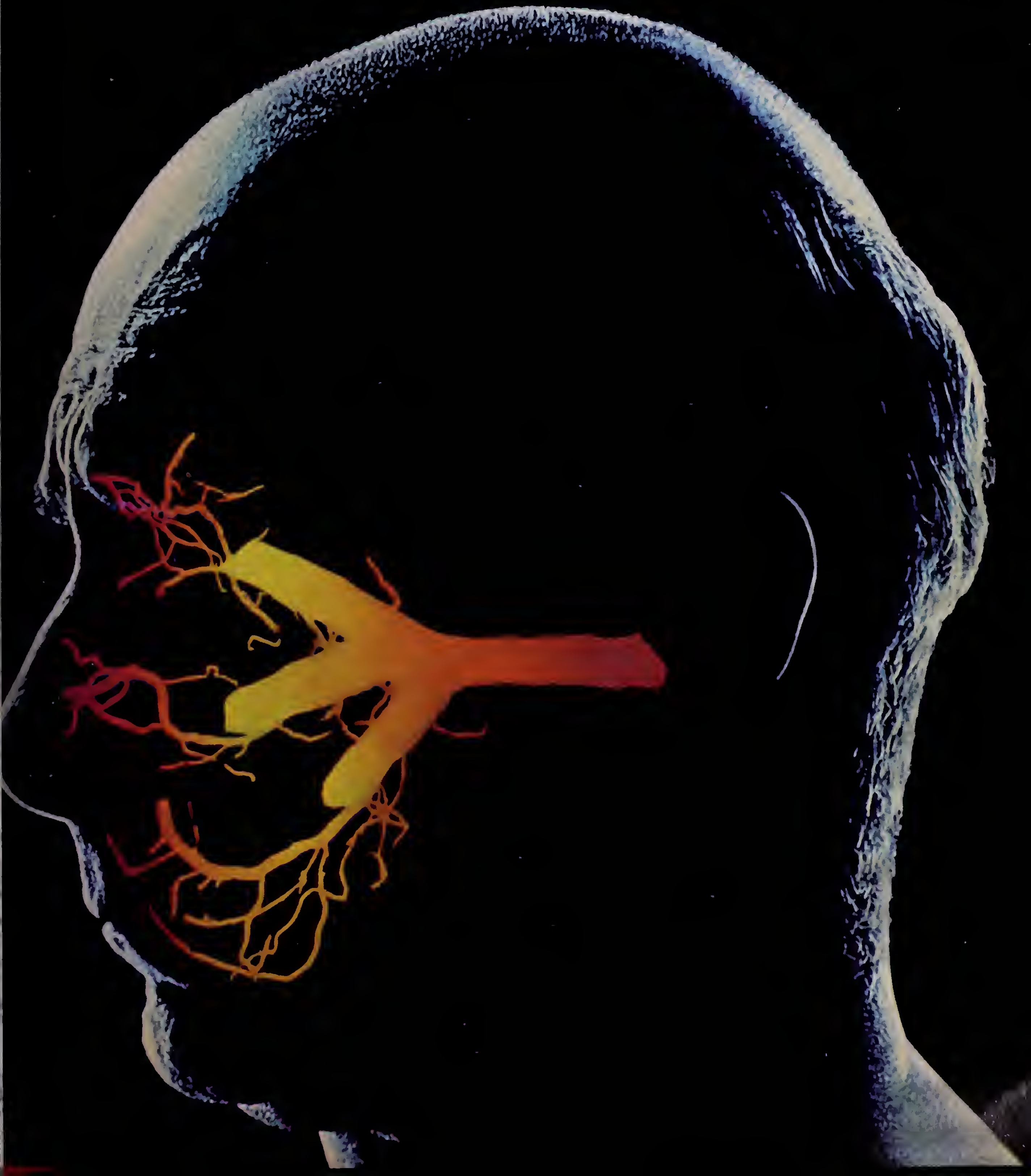
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent
laboratory and clinical evaluations. Should this trend continue, the
should be discontinued.
2. Liver function tests must be performed at regular intervals during
ment with this drug since liver damage may occur during therapy. T
drug should be discontinued immediately in cases of aggravated li
dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and to
etry, are recommended for patients being treated with this drug sin
many phenothiazines and related drugs have been shown to cause
changes.
4. Complete urinalysis and BUN should be done on patients treate
Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet
nausea, vomiting, aplastic anemia, transitory leukopenia, agranuloc
eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalitie
liver function tests, cholestatic and hepatocellular jaundice, urinary
quency, acute urinary retention, oliguria with elevated blood pressu
albuminuria, glycosuria, elevated BUN, microscopic deposits in the
impotence, disturbances of coordination, confusion, headache, fatig
blurred vision, transient diplopia and oculomotor disturbances, spe
disturbances, abnormal involuntary movements, peripheral neuritis
paresthesias, depression with agitation, talkativeness, nystagmus, ti
nitus, paralysis and other symptoms of cerebral arterial insufficienc
pruritic and erythematous rashes, urticaria, Stevens-Johnson syndr
photosensitivity reactions, alterations in skin pigmentation, exfoliati
dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, e
multiforme and nodosum, aggravation of disseminated lupus erythe
tosus, gastric distress, abdominal pain, diarrhea, constipation, ano
dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills,
adenopathy, lymphadenopathy, aching joints and muscles, leg cra
conjunctivitis, left ventricular failure, aggravation of hypertension, h
tension, syncope and collapse, edema, aggravation of coronary arte
disease and congestive heart failure. (Whether these cardiovascula
are drug-related is not known. However, some of these complicatio
resulted in fatalities.) The necessity for discontinuing the drug shou
dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with r
if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, th
should be increased in one-half tablet (100 mg.) increments every 1
until freedom from pain is achieved. To relieve pain, between 200 m
1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patie
with a dose of 400 mg. to 800 mg. daily. Maintenance doses may ra
between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shou
made to discontinue the drug or to reduce the dose to the minimum
effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottl
of 100 and 1000.
(B)46-8
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Gei

uncommon relief of uncommon pain



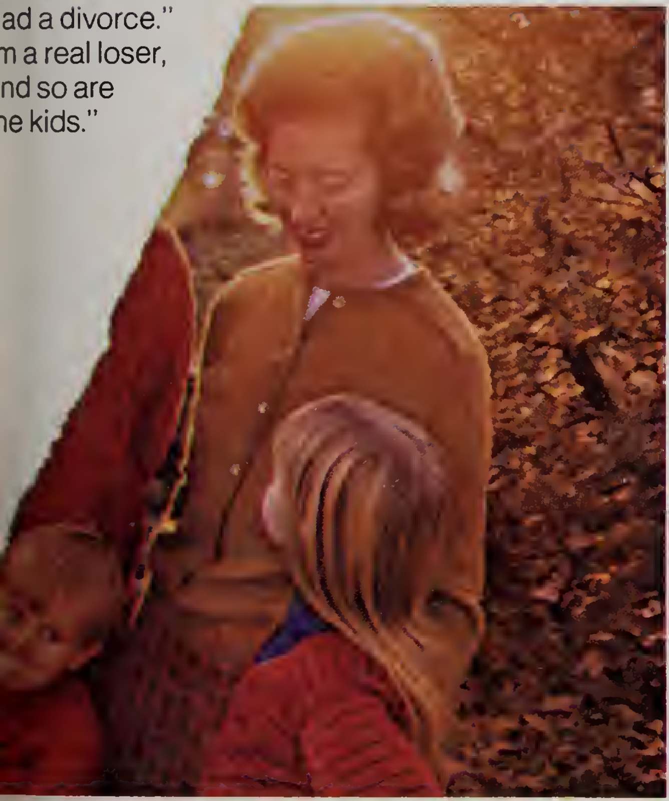
The Divorced Depressive: “Forty Forgotte

“Had a large wedding.”
“Had a fine home and family.”

TO-5757

.Forlorn"

ad a divorce."
m a real loser,
nd so are
e kids."



The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy – the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

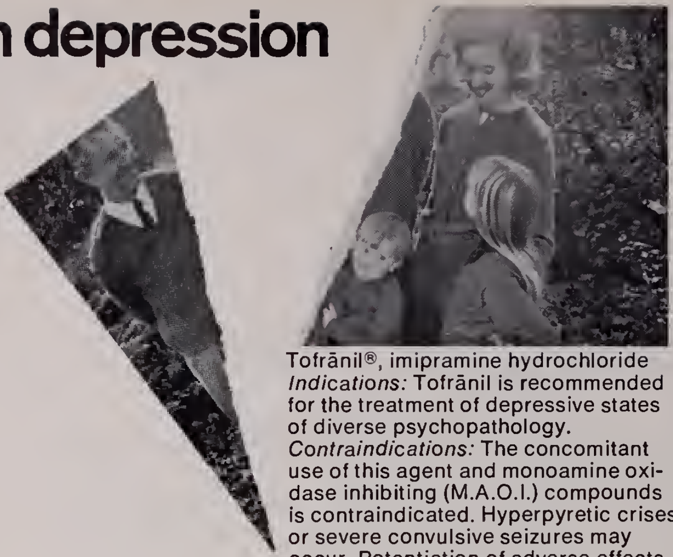
in depression **Tofrānil®** imipramine hydrochloride

Geigy

in depression

Tofrānil® Geigy

imipramine
hydrochloride



Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

Donnagel®
A·H·ROBINS
For treatment of Diarrhea
4 fl oz
SHAKE WELL

"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN

THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Pheniramine maleate . . . . . . 7.5 mg.
Codeine phosphate . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

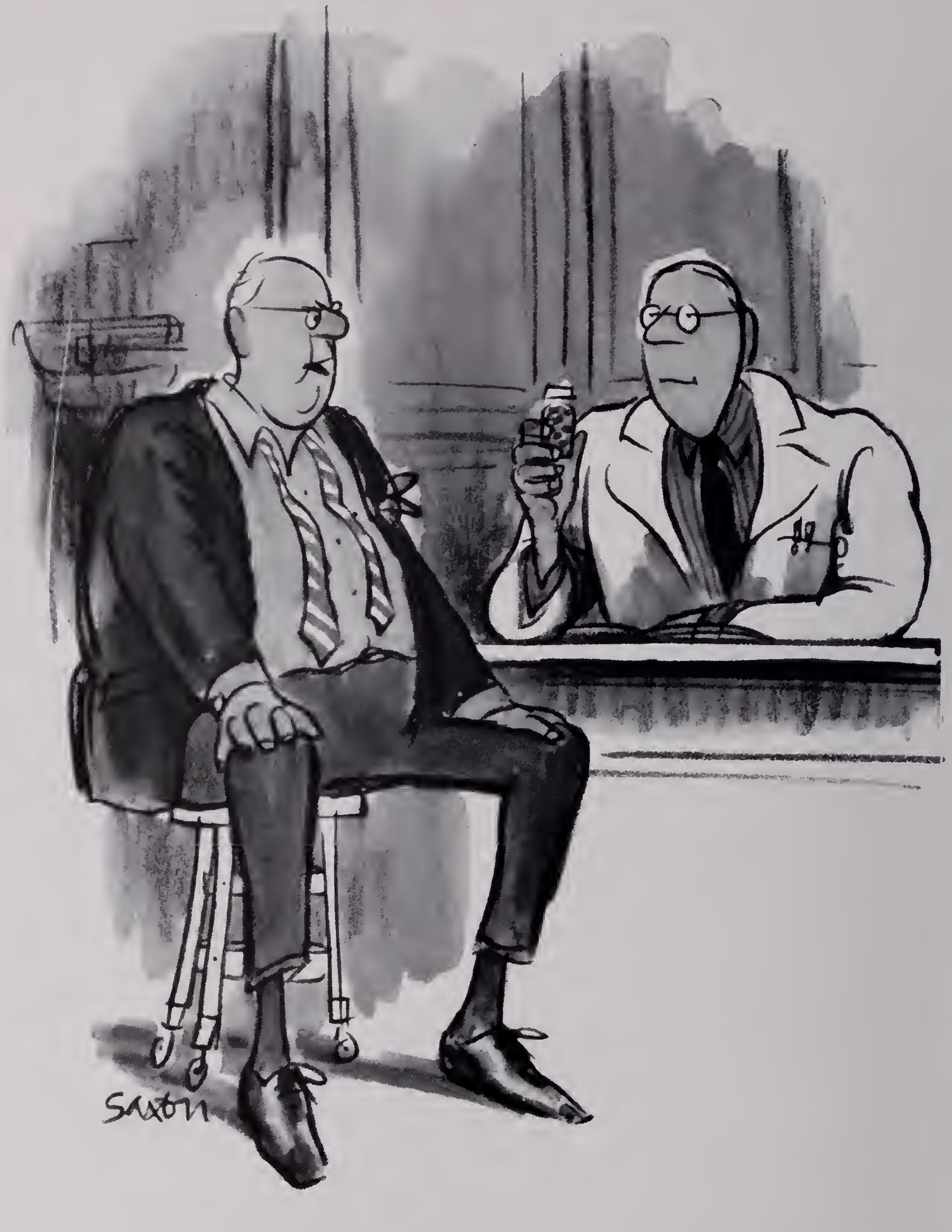
Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Say you saw it in Michigan Medicine

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

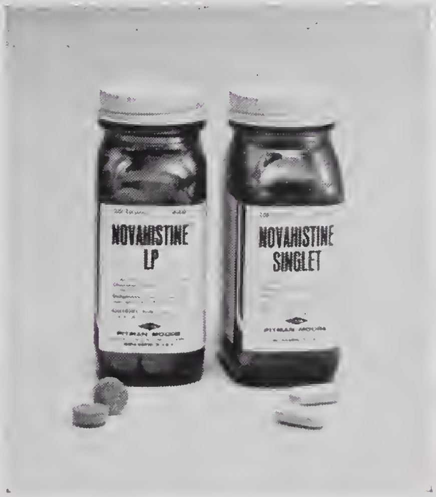
Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

DOW **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



An anorectic will help her lose weight– but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite ontrol plus mood levation

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg.
10 mg.
15 mg.

For patients who can't ake plain amphetamine

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

Veight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the
secret
of
controlling
your weight

Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444

To
help you
control your
weight

lease see Brief Summary n next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

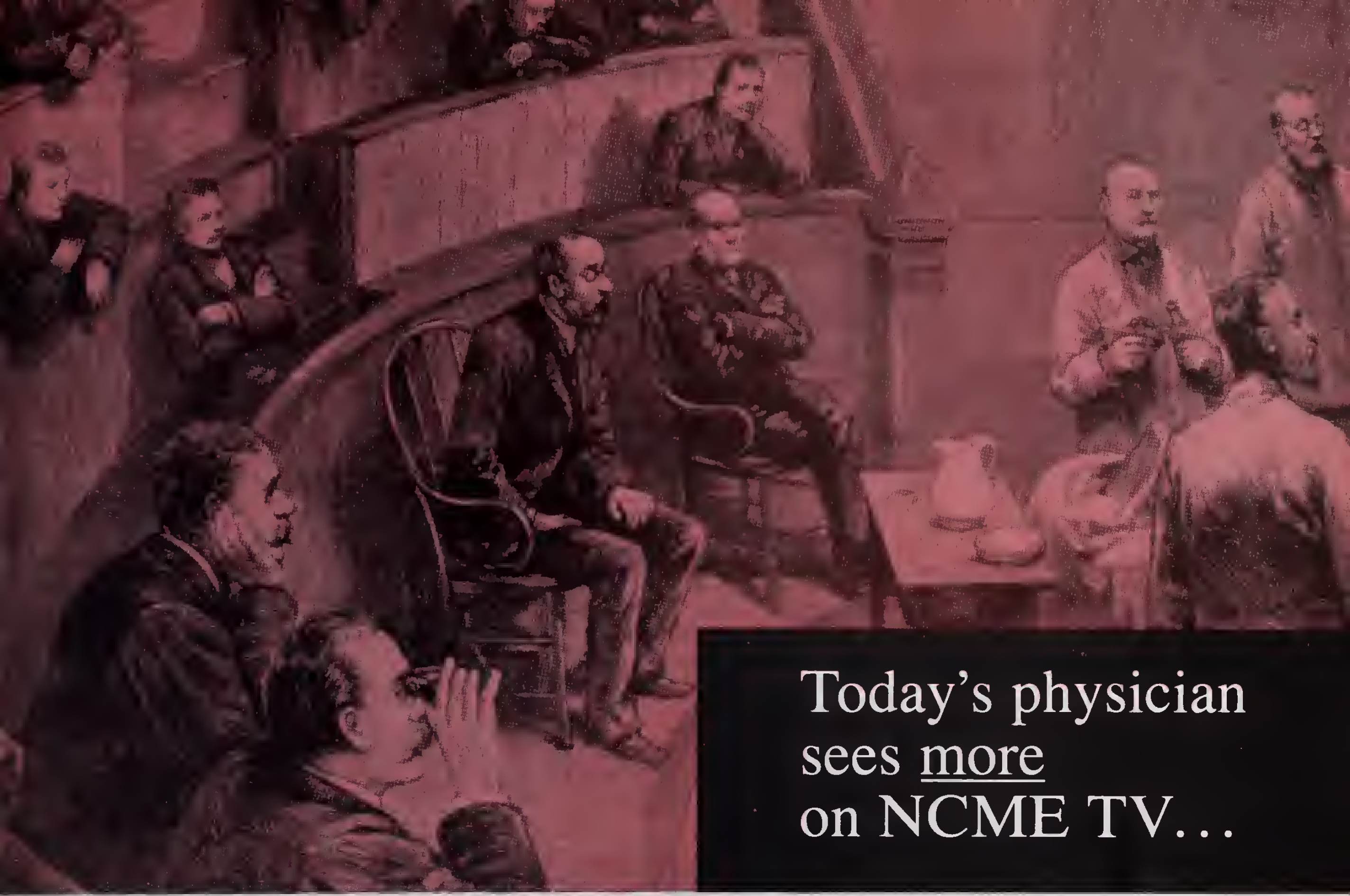
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*
anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064



Today's physician
sees more
on NCME TV…

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The Network
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Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to
NCME, 342 Madison Avenue
New York, N.Y. 10017

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

a stuffy nose
is no
laughing matter

Ornade® Trademark

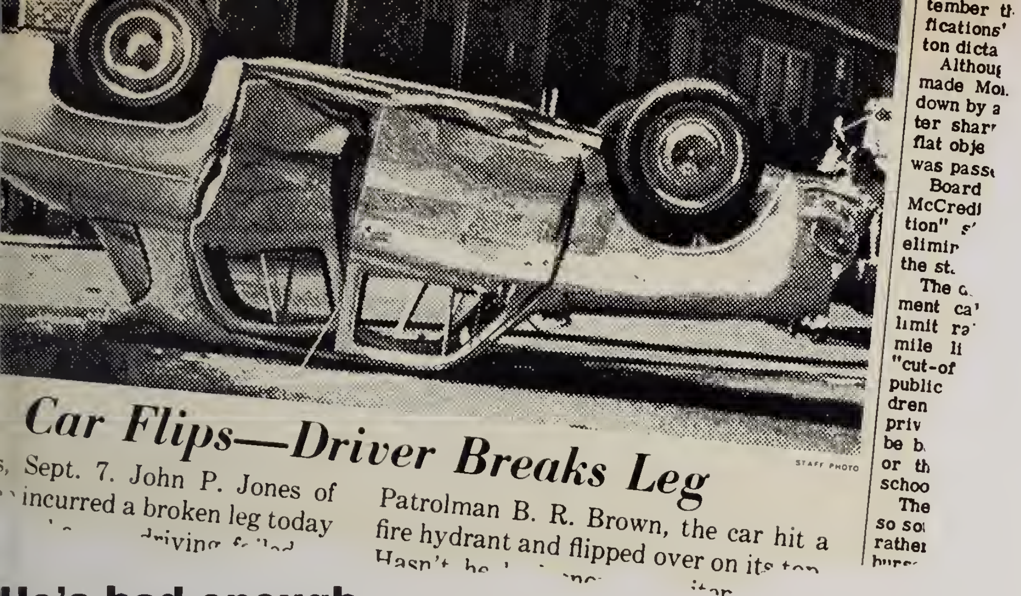
Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can
give him all-day
or all-night relief
of nasal congestion

SK&F Smith Kline & French, Laboratories



Car Flips—Driver Breaks Leg

STAFF PHOTO

, Sept. 7. John P. Jones of
incurred a broken leg today

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

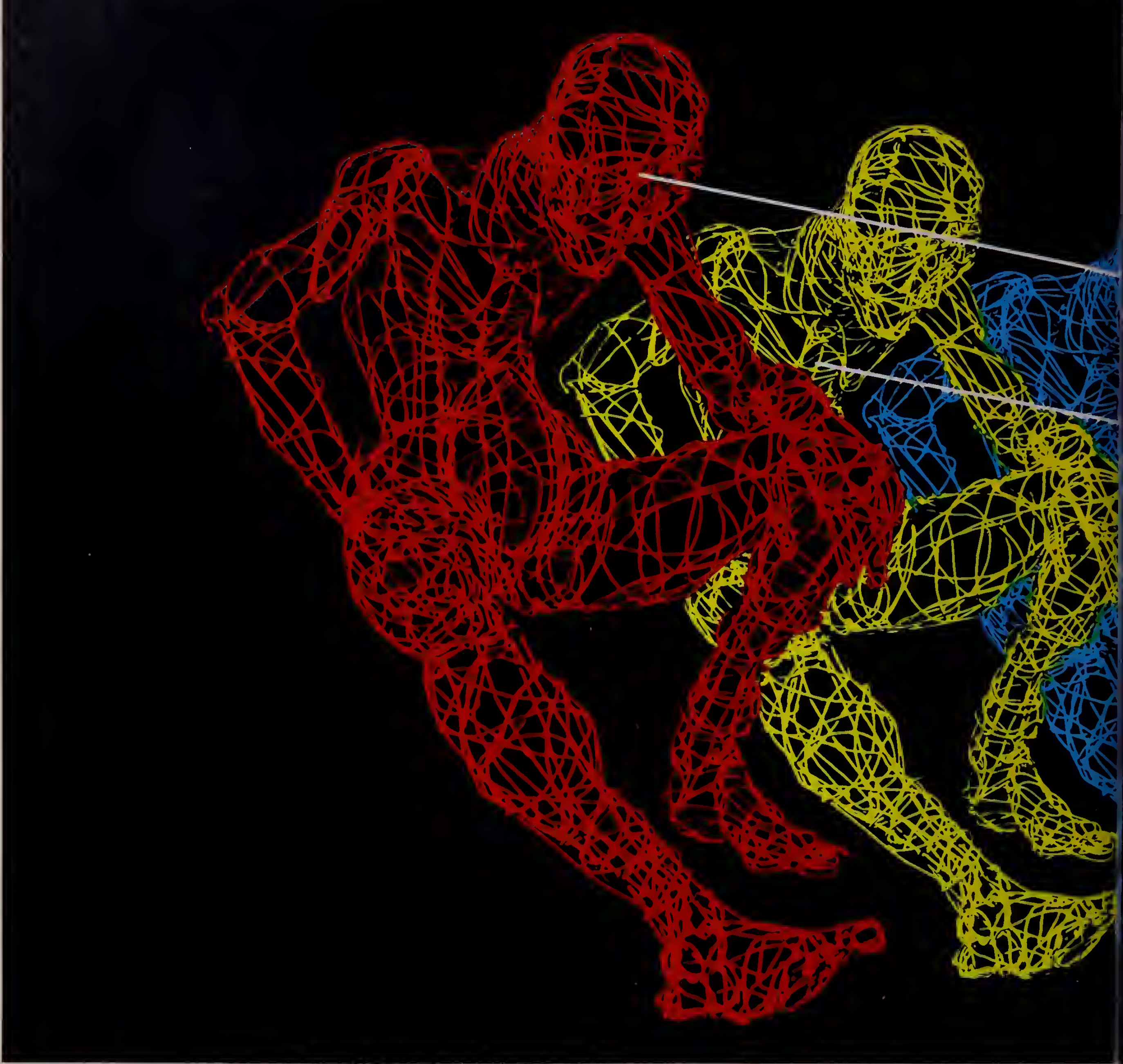
Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A-H-ROBINS

a comprehensive hematinic



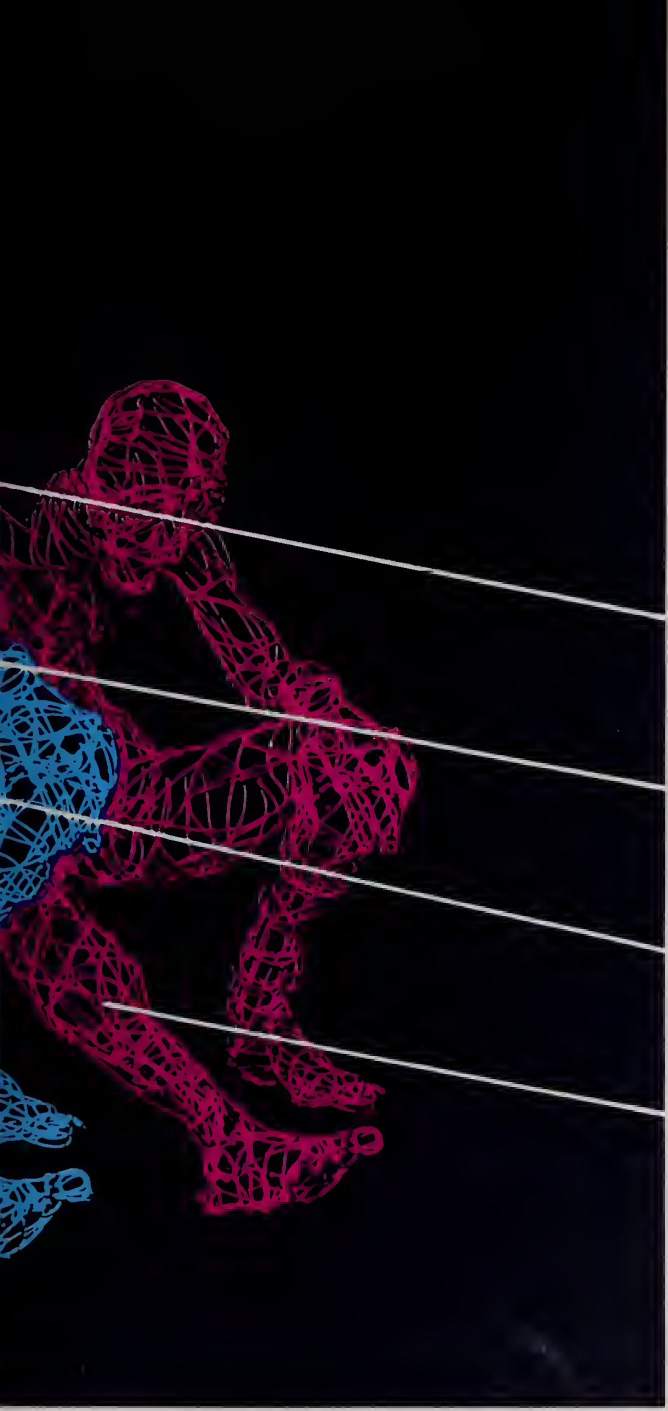
Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires approp
investigation to determine its cause or causes.
In pernicious anemia, the use of folic acid without adec
vitamin B_{12} therapy may result in hematologic remission but
rological progression. Adequate doses of vitamin B_{12} (paren
or oral with potent intrinsic factor as in Trinsicon® [hema
concentrate with intrinsic factor, Lilly]) usually prevent, ha
improve the neurological changes.
As with all preparations containing intrinsic factor, resist
may develop in some cases of pernicious anemia to the pote
tion of absorption of physiological doses of vitamin B_{12}. If r
ance occurs, parenteral therapy, or oral therapy with so-c
massive doses of vitamin B_{12}, may be necessary. No single
men fits all cases, and the status of the patient observe
follow-up is the final criterion for adequacy of therapy. Per



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has ollowed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with ntrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information
available to physicians
upon request.
Eli Lilly and Company,
Indianapolis, Indiana 46206.
801668

Lilly

In peptic ulcer:

the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"
Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?
Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"
The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
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Michigan State Medical Society

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

F. A. Nick, M.D., Ypsilanti,
has been selected team physician for the Olympic team for Iran. The Olympic Games in Mexico City will not be the first he has attended, as Doctor Nick was himself once a member of the Iranian team. A six-time national boxing champion of Iran, he competed as a bantamweight in the 1952 Games in Helsinki, Finland. Former ringside physician in the Florida Golden Gloves while serving his residency in Jacksonville, he now is a member of the Washtenaw County Medical Society's committee on athletics and of the American College of Sports Medicine.

Lynn D. Allen, M.D., Pontiac,
recently was reappointed by the Pontiac City Council to the Pontiac General Hospital Board of Directors. He was first appointed 10 years ago.

Donald H. Kaump, M.D., Ann Arbor,
has been promoted to director of the new Parke-Davis department of pathology and toxicology and will also serve as acting director of the department of experimental therapeutics. He is a special lecturer in pathology at the University of Michigan Medical School.

Edward F. Crippen, M.D., Detroit,
formerly of Mancelona and more recently Deputy Commissioner of Health for the City of Detroit, has begun his new duties as Nevada State Health Officer in Carson City.

Arthur C. Curtis, M.D., Ann Arbor,
will address the annual leadership conference of the American Social Health Association in New York City Oct. 27-28 when the voluntary agency meets to consider "Venereal Disease Research Priorities: Biologic, Behavioral and Control." Doctor Curtis, professor of dermatology, University of Michigan, will speak about plans and priorities in control measures of the nongovernmental organization.

William B. Weil, Jr., M.D., East Lansing,
chairman of MSU's new Department of Human Development, has been named president-elect of the Society for Pediatric Research. He has been secretary of the society since 1962.

Vernon V. Bass, M.D., Saginaw,
Vice-Speaker of the MSMS House of Delegates, spoke to the Ottawa County Medical Society October 4 during a program exploring various possible projects and activities for county medical societies.

John J. Hanlon, M.D., Detroit,
began new duties in September as the Assistant Surgeon General in the Public Health Service in Washington. He formerly had been Commissioner of Health of the City of Detroit and head of the WSU Medical School Department of Community Medicine.

Shirley Austin, M.D., Detroit,
spoke at the MSMS pre-convention news luncheon in Detroit September 18. She discussed "Relief of Pain" for the press, radio and television reporters.

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VOLUME 67, NUMBER 20 • OCTOBER 1968 • DEADLINE FOR COPY, OCTOBER 14, 1968

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

COLLEGE OF PHYSICIANS OF PHILADELPHIA
OCT 30 1968
S 3

House Re-Elects Blodgett, Bass

Lightbody Installed; Mason Elected Next President; Taylor to Head Council

The leadership of MSMS today lines up with:

President: James J. Lightbody, M.D., Detroit

President-Elect: Robert J. Mason, M.D., Birmingham

Speaker: James B. Blodgett, M.D., Detroit

Vice-Speaker: Vernon V. Bass, M.D., Saginaw

Council Chairman: Ross V. Taylor, M.D., Jackson

Council Vice-Chairman: Ralph R. Cooper, M.D., Detroit

These men were installed, elected, or re-elected at the 1968 Annual Session of the MSMS House of Delegates in Detroit, along with others who were selected to serve on The MSMS Council or in the MSMS delegation to the AMA House of Delegates.

The MSMS House of Delegates, at its closing session, September 24, unanimously elected Doctor Mason as the President-Elect. He had served as Chairman of the MSMS Council for two years, and had been a member of The Council, representing Oakland-Macomb, for nine years.

At that final session, the delegates re-elected Speaker Blodgett and Vice-Speaker Bass for their second terms. The delegates praised them for their excellent handling of the 1968 business meeting. Doctor Lightbody was installed as the new President at a special Delegates Dinner September 22 to succeed B. M. Harris, M.D., who completed his year as MSMS President.

When The MSMS Council reorganized on September 24, the councilors elevated Doctor Taylor from Vice-Chairman to the Chairmanship. Doctor Cooper was elected Vice-Chairman and the Chairmen of the three Standing Committees were all re-elected—Robert K. Whiteley, M.D., Finance; John J. Coury, M.D., County Societies, and Brooker L. Masters, M.D., Publication.

Four delegates and four alternate delegates were re-elected for two-year terms in the AMA House of Delegates. All were unopposed. Returned as Delegates were Sidney Adler, M.D., Detroit; George W. Slagle, M.D., Battle Creek; Don-

(Continued on Page 1304)

The royal purple ribbon with the MSMS President's Key is placed over the head of James J. Lightbody, M.D., at the 1968 Annual Session to signify his installation as President for 1968-69. The key was passed on by B. M. Harris, M.D., who then received a Past President's Scroll from the new President.

Party Platforms on Health:

The two party conventions adopted platforms which have been explained by the candidates during the current campaign.

Following are the platform statements by each about health:

DEMOCRATIC

The best of modern medical care should be made available to every American. . . .

Through a partnership of government and private enterprise we must develop new coordinated approaches to stem the rise in medical and drug costs without lowering the quality or availability of medical care. Out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides can all contribute. . . .

We will raise the level of research in all fields of health. . . .

We must build new medical, dental and medical service schools, and increase the capacity of existing ones. . . .

Medical care should be extended to disabled beneficiaries under the Old Age, Survivors and Disability Insurance Act to the same extent and under the same system that such care is available to the aged. . . .

Maternal and child health centers, located and designed to serve the needs of the poor, and voluntary family planning information centers should be established throughout the country.

Medicaid programs administered by the states should have uniform standards. . . .

We urge consideration of a program comparable to Medicare to finance pre-natal care for mothers and post-natal care for children during the first year of life.

REPUBLICAN

We pledge to encourage the broadening of private health insurance plans, many of which cover hospital care only, and to review the operation of government hospital care programs in order to encourage more patients to utilize non-hospital facilities.

Expansion of the number of doctors, nurses and supporting staff . . . will have our support.

We will foster the construction of additional hospitals and encourage regional hospital and health planning. . . .

We will also press for enactment of . . . programs for financing of hospital modernization. . . .

New diagnostic methods and also preventive care to assure early detection of physical impairments . . . will have our support.

We will work with states and local communities to help assure improved services to the mentally ill within a community setting and will intensify research to develop better treatment methods. We will encourage extension of private health insurance to cover mental illness.

While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship. . . .

VOTE AS YOU PLEASE
BUT VOTE!

Continued: 1968 House of Delegates, Council Elects

ald N. Sweeny, Jr., M.D., Detroit, and Joseph A. Witter, M.D., Highland Park. Continuing to serve as Alternates are James C. Danforth, Jr., M.D., Detroit; John J. Coury, M.D., Port Huron; Marjorie Peebles Meyers, M.D., Detroit, and Vernon V. Bass, M.D., Saginaw.

Continuing to serve another year as Delegates are Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Royal Oak; and Robert E. Rice, M.D., Greenville; and as Alternate Delegates, Harold A. Furlong, M.D., Pontiac; B. M. Harris, M.D., Ypsilanti; Paul T. Lahti, M.D., Royal Oak; and John W. Moses, M.D., Detroit.

The delegates elected two new members of The MSMS Council. Sydney Scher, M.D., Mt. Clemens, to succeed Doctor Mason representing the 15th District; and Wm. A. LeMire, M.D., Escanaba, to succeed Eugene R. Elzinga, M.D., Marquette, who was not a candidate, representing the 12th District.

Returned to The Council were Milton R. Weed, M.D., Grosse Pointe Park, 1st District; John J. Coury, M.D., Port Huron, 7th District; A. Carl Stander, M.D., Saginaw, 8th District; and Edward H. Rodda, M.D., Bay City, 10th District.

THE PROCEEDINGS WILL BE PRINTED IN DECEMBER AS PART OF JOURNAL

Unofficial Summary of House Action

BY JAMES B. BLODGETT, M.D.
SPEAKER, HOUSE OF DELEGATES

The following summary report of the proceedings of the 103rd (1968) House of Delegates of the Michigan State Medical Society is *UNOFFICIAL.*

It is designed to assist delegates in reporting to their medical societies prior to the publication of the official stenotyped record which is printed in *Michigan Medicine,* the Society's monthly journal.

One-hundred-sixty-two Delegates and 23 Section Delegates considered 70 resolutions (a 15% increase over 1967), a 12-page comprehensive report of the past year's activities of the MSMS Council, an 11-page report plus supplement from Michigan Medical Service, the summary of activities of the 53 committees of the Society, The Council and the House of Delegates, and numerous special reports.

The following decisions of the House as the legislative body of MSMS shape the policy and course of the Michigan State Medical Society for 1968-69.

MATTERS OF GENERAL MSMS BUSINESS

The House amended the Bylaws to permit a partial waiver of MSMS dues if this action is also taken by the component county society due to the member's illness, disability or straited financial circumstances. (Resolution 13)

The House divided the Society's scientific section on Psychiatry and Neurology into separate sections on each specialty. (Resolution 14)

The House favored annual reappointment to the active medical staff of a hospital, stating that reappointment should not be denied except for medical ineptitude, character deficiency, conviction of unethical conduct, revocation of license by the State, or violation of those bylaws, rules or regulations of the hospital which have been approved by the medical staff. (Resolution 18 as amended)

The House directed that the Joint Commission on Accreditation of Hospitals be asked to require "Hospital Care Committees" in all hospitals as a condition of accreditation, composed of physician members of the staff, to review all aspects of hospital-provided (as opposed to physician-provided) patient care. (Resolution 37)

The House urged the American Medical Association to take leadership to combat crime and delinquency by studying the medical aspects of the same. (Resolution 45)

The House directed the official establishment of liaison with all Michigan Student American Medical Association groups; the House also resolved to increase financial support to all Michigan SAMA chapters. (Resolution 52)

The House requested that a program be developed to provide limited affiliate membership in local county medical societies for medical students. (Resolution 53)

The House instructed The Council of MSMS to seek a grant for the purpose of conducting a pilot study on ways and means to improve efficiency in the hospital care of patients. (Resolution 10)

The House urged all physicians to consider carrying excess professional liability (coverage at least $1,000,000) since awards in many cases far exceed the usual $100,000 coverage. A study of ways and means to reduce the cost of adequate coverage will be made and reported to the 1969

Members of the Oakland County Medical Society escort Robert J. Mason, M.D., to the rostrum of the House of Delegates after the delegates chose the Birmingham physician as President-Elect. The three men who can be identified behind Doctor Mason are Harold A. Furlong, M.D., Pontiac, who made the nominating speech; Paul T. Lahti, M.D., Royal Oak, and Richard R. Galpin, M.D., Pontiac, Oakland president.

Continued: Unofficial Summary of House Action

House. (Reference Committee on Professional Liability Insurance)

The House commended the MSMS Woman's Auxiliary for their contributions to World Medical Relief and the AMA Education Research Foundation and their general valuable aid to the State Society. (Reference Committee on Reports of Council and Officers)

The House recognized the importance of physicians' contributions to the health and welfare of humanity through counseling their patients in family planning. (Resolution 6)

The House requested a study of the problem of investigating complaints against physicians who are not members of MSMS. (Resolution 16 as amended)

The House directed that the matter of water pollution be given increased emphasis by the MSMS. (Resolution 21 as amended)

The House requested Michigan medical schools to intensify their efforts to encourage their graduates to practice in Michigan, and also asked that all appropriate lay groups (Chambers of Commerce, etc.) be encouraged to take similar action. (Resolution 38 and 69)

The House highly commended the Michigan Doctors Political Action Committee and urged every member to personally become active in MD-PAC and the political process. (Resolution 64)

The House empowered The Council to exercise its own judgment in proceeding to obtain group liability insurance. (Reference Committee on Reports of Council and Officers)

The House asked The Council to make every effort to confine the direction and supervision of medical laboratories to licensed physicians. (Resolution 56)

The House directed The Council to condemn all cigarette advertising on television, and also direct the Michigan AMA delegation to introduce a resolution in the AMA House calling for similar action by that body. (Resolution 58)

The House directed the Michigan AMA delegates to introduce a resolution in the AMA House requesting deletion of the AMA Reinstatement Fee. (Resolution 35)

MATTERS PERTAINING TO LEGISLATION AND GOVERNMENT

The House opposed a proposed revision to the Michigan Criminal Code which would make it a felony to violate the administrative rule of a state agency. (Resolution 9)

The House urged the strongest possible support of appropriate legislative action to fully develop the University of Michigan, Wayne State University, and Michigan State University medical schools (expansion of the latter to a full MD degree program). (Substitute Resolution for Resolutions 26 and 27)

The House directed introduction of a bill in the Michigan Legislature to extend the legal protection from liability now granted in Public Act 270 of 1967 to in-hospital staff committees to those county medical societies, MSMS and specialty society committees which develop confidential information to reduce morbidity or mortality or to promote medical education and research. (Resolution 31)

The House directed that MSMS support legislation which will allow minors to give their own consent for examination for and treatment of venereal disease. (Resolution 33)

The House requested that the Board of Registration in Medicine explore all means of mechanically streamlining their examination functions (computerization, etc.). (Resolution 34 as amended)

The House expressed opposition to any legislation that would in any way degrade the profession and dignity of a registered nurse or in any way equate the status of a registered nurse with persons of less training. (Resolution 42)

The House encouraged the enactment of legislation which will more strictly enforce the existing laws relative to driving while drunk and impose more severe penalties for violations thereof, detect and prosecute the reckless or careless driver, and provide for a more careful and appropriate interval examination of all drivers. (Resolution 62 as amended)

The House directed that the Michigan Department of Social Services be advised to make any necessary changes, including legislative if necessary to provide direct payment to Title 19 Group 2 patients. (Resolution 63 as amended)

The House reiterated that "in the future, payments from all governmental agencies should be on the same basis" (the usual, customary and reasonable fee) as Title 18B Medicare, and that this recommendation be forwarded to all county medical societies for use in negotiating with local governmental agencies. (Reference Committee on State and Federal Legislation)

The House directed the Michigan AMA delegation to present a resolution to the AMA House seeking to eliminate present recertification requirements for Medicare and Medicaid patients. (Substitute for Resolutions 1 and 61, Reference Committee on Health Insurance and Medical Service)

The House asked the Michigan AMA delegation to introduce a resolution in the AMA House in support of a Uniform National Medical Licensing Examination. (Resolution 15)

The House directed the Michigan delegation to urge the AMA House to strongly support increased subsidies to hospital nursing schools. (Substitute for Resolution 57 and 59, Reference Report on State and Federal Legislation)

The House referred continuing study of feasible malpractice legislation to The Council for referral to an appropriate study committee. (Resolution 2)

The House referred specific recommendations regarding Medical Examiner Legislation to The Council for referral to the committee presently working in this area. (Resolution 54)

The House directed the Speaker to review the "Single Medical Practice Act" which had been referred to it. The Speaker was directed to appoint an ad hoc committee of the House, including representative of the Board of Registration in Medicine and the Legal Affairs Committee, and included Legal Counsel, to review it. The ad hoc committee will obtain the views of each county medical society. The Council is empowered to take any necessary action in this area. (Reference Report of Reports of Council and Officers)

The House adopted a resolution and accompanying policy guidelines on therapeutic abortion both of which are to be considered together as a single document. The resolution recommends change in the Abortion Laws of Michigan, and the policy guideline sets forth the House's view of the controls which should be exercised over abortions performed by licensed MDs and DOs in licensed and accredited hospitals. The resolution reads:

> Whereas, the current abortion laws of the State of Michigan are very restrictive so that only a very few women may receive legal abortions, and
>
> Whereas, all data indicate that despite these laws many women do receive criminal abortions and in the process many times seriously endanger their physical and mental health, and
>
> Whereas, all of the current abortion law reform bills are limited in their scope so that very few women would have the right to obtain an abortion, and
>
> Whereas, the right to bear a child should be primarily determined by the woman and her husband, therefore be it
>
> RESOLVED: That the Michigan State Medical Society urge the Michigan Legislature to so alter the abortion laws that the criminal code will not apply to abortions performed by licensed medical and osteopathic physicians in an accredited hospital licensed by the State.

The policy guidelines states:

> "Therapeutic abortion is a medical procedure. Accordingly the Michigan State Medical Society recognizes this responsibility to render available scientific medical information with respect to therapeutic abortion to legislators, authorized committees, the public, and finally and most importantly patients. Nowhere in the progression of therapeutic abortion legislation or practice should sight be lost of the fundamental principle that the primary decision belongs to the patient. This decision must be based on an informed understanding of the nature and the consequences of the therapeutic abortion and should be coupled with the informed consent of the husband if any and the parents and/or legal guardian if the patient is a minor. The Michigan State Medical Society respectfully recognizes that some physicians because of moral or religious grounds oppose liberalization of the abortion laws. Therefore, no physician or hos-

MORE ARTICLES AND PHOTOS OF 1968 ANNUAL SESSION WILL APPEAR IN NOVEMBER ISSUE OF MICHIGAN MEDICINE

pital should be compelled directly or indirectly to perform a therapeutic abortion.

In view of the above, the Michigan State Medical Society believes that therapeutic abortion may be authorized subject to the following conditions:

1. A licensed medical or osteopathic physician perform the abortion in an accredited hospital licensed by the state.
2. Two other doctors of medicine or osteopathy concur in writing that one of the following conditions exist:
   a) The abortion is deemed necessary to preserve the life of the pregnant female; or
   b) The abortion is deemed necessary to preserve the physical or mental health of the pregnant female; or
   c) That the infant may be born with incapacitating physical deformity or mental deficiency; or
   d) That 3 doctors of medicine or osteopathy believe that the pregnancy resulted from forcible rape or incest.
3. MSMS does not condone the concept that an abortion be performed on demand for any unwanted pregnancy or as a means of birth control. We do not believe, however, that in determining whether or not there is a risk to the pregnant woman's life or health account must be taken of the patient's total environment considering such factors as parity, contraceptive failure, socio-economic stress, or marital or family stress when a woman does request a therapeutic abortion."

MATTERS DEALING WITH PARAMEDICAL AND ALLIED SUBJECTS

The House urged that all Michigan hospital administrative staffs inform all ancillary medical personnel not to discuss a patient's diagnosis or treatment, or the qualifications or direction of any physician or nurse, with or in the presence of the patient. (Resolution 17)

The House endorses the principle of a "balanced patient load" for nursing homes rather than the categorizing of certain homes as "basic" and others as "skilled." (Resolution 43)

The House urged the subcommittee on Para-Medical Education of the Education Liaison Committee to continue with its development of a program for the education of physician's assistants. (Resolution 48)

The House highly commended the activities of the Michigan State Assistants Society and recommended membership in MSMAS for all eligible persons. (Reference Committee on Reports of Council and Officers)

The House encouraged continuing activity of the Liaison Committee with Podiatry. (Reference Committee on State and Federal Legislation)

The House directed The Council to seek a grant to conduct a "pilot study to improve hospital efficiency." (Resolution 10)

The House referred to The Council for its further consideration the project of a study of osteopathic training programs. (Resolution 41)

The House directed The Council to ask the Health Insurance Council to explore the inclusion of out-patient physical therapy by a licensed physical therapist as a benefit in all policies. (Resolution 22 as amended)

The House asked The Council to request the State Board of Education to turn its attention to developing nursing education programs following specific guidelines as set forth in resolutions 57 and 59. (Reference Report on State and Federal Legislation)

The House directed that the Joint Commission on Accreditation of Hospitals be asked to require "Hospital Care Committees" in all hospitals as a condition of accreditation, composed of physician members of the staff, to review all aspects of hospital-provided (as opposed to physician-provided) patient care. (Resolution 37)

The House encouraged the enactment of legislation which will more strictly enforce the existing laws relative to driving while drunk and impose more severe penalties for violations thereof, detect and prosecute the reckless or careless driver, and provide for a more careful and appropriate interval examination of all drivers. (Resolution 62 as amended)

The House referred continuing study of feasible malpractice legislation to The Council for referral to an appropriate study committee. (Resolution 2)

MATTERS PERTAINING TO BLUE SHIELD AND PREPAYMENT PLANS

The House requested a Michigan Medical Service study of the possibility of making regional anesthesia administered by the attending physician a compensable benefit. (Resolution 32 as amended)

The House asked the Michigan Medical Service Board of Directors to carefully review its advertising policies relative to the MVF plan to eliminate error or confusion by doctors and subscribers. (Resolution 39 as amended)

The House recommended to Blue Shield that it annually announce to its subscribers the percentage of the premium paid to Blue Cross and the percentage to Blue Shield so that they will know the ratio between physician remuneration and defraying of hospital costs. (Resolution 49)

The House endorsed, in principle, the Michigan Variable Fee Program of Michigan Blue Shield. (Resolution 55 as amended)

The House urged Michigan Medical Service to resist to the full extent of its ability, any effort of the Secretary of Health, Education and Welfare to take over confidential records or data pertaining to Michigan physicians. (Resolution 67)

The House adopted the Michigan RVS as revised in 1968, and directed that this valuable reference for physicians be revised annually if necessary. (Reference Report on Health Insurance and Medical Service)

The House commended Michigan Medical Service for its demonstrated management efficiency in improving its ability to handle vastly expanding business operations. (Reference Report on Health Insurance and Medical Service)

The House referred to The Council, for referral to a committee for further study, the proposition of revising Blue Shield's method of payment to physicians. (Resolution 44)

The House directed the Michigan AMA delegation to present a resolution to the AMA House seeking to eliminate present recertification requirements for Medicare and Medicaid patients. (Substitute for Resolutions 1 and 61, Reference Committee on Health Insurance and Medical Service)

The House asked that every county medical society be represented by at least one physician on a "Regional Advisory Committee to Blue Shield," the regions to be councilor districts or combinations thereof, to review claims, utilization frequency and charge patterns, and arbitrate fee disputes. The members of such review committees are to report back to their county societies. (Resolution 29 as amended)

MATTERS PERTAINING TO COUNTY MEDICAL SOCIETIES

The House urged all component county medical societies and medical staffs of hospitals to conduct one meeting a year on the subject of the legal problems of medical care. (Resolution 17)

The House resolved to intensify dissemination of specific information to county medical societies regarding State Comprehensive Health Planning and the role of the county society in providing leadership for this program. (Resolution 3 as amended)

The House urged each county medical society to develop citizens groups to support Medicine's effort to bring the University of Michigan, Wayne State University and Michigan State University to full potential function in training doctors of medicine. (Reference Report on Report of Council and Officers)

The House requested each county medical society to take an active interest in training ambulance personnel and in upgrading ambulance service. (Resolution 25)

The House asked that every county medical society be represented by at least one physician on a "Regional Advisory Committee to Blue Shield," the regions to be councilor districts or combination thereof, to review claims, utilization frequency, and charge patterns, and arbitrate fee disputes. The members of such review committees are to report back to their county societies. (Resolution 29 as amended)

The House directed the Speaker to review the "Single Medical Practice Act" which had been referred to it. The Speaker was directed to appoint an ad hoc committee of the House, including representative of the Board of Registration in Medicine and the Legal Affairs Committee, and including Legal Counsel, to review it. The ad hoc committee will obtain the views of each county medical society. The Council is empowered to take any necessary action in this area. (Reference Report of Reports of Council and Officers)

The House requested that a program be developed to provide limited affiliate membership in

---

The formal presentation of Marjorie Peebles Meyers, M.D., as the "Outstanding Physician of the Year" was made by Speaker James B. Blodgett, M.D., at the Delegates Dinner. (Details of the award and the service record of Doctor Meyers appeared in the October issue of **Michigan Medicine.**)

local county medical societies for medical students. (Resolution 53)

The House reiterated that "in the future, payments from all governmental agencies should be on the same basis" (usual, customary and reasonable fee) as Title 18B Medicare, and that this recommendation be forwarded to all county medical societies for use in negotiating with local governmental agencies. (Reference Committee on State and Federal Legislation)

MATTERS PERTAINING TO COMMITTEES

The House authorized establishment of a liaison committee between MSMS and the Michigan Hospital Association. (Resolution 7)

The House requested the liaison committee between MSMS and the Michigan Bar Association to make recommendations (by September 1969) regarding the legality and advisability of a law requiring that, if it is voluntarily agreed to by both parties, arbitration in malpractice suits be binding. (Resolution 20 as amended)

The House requested the standing committee on Constitution and Bylaws to study the question of MSMS referendum by petition and the use of mail ballots (Resolution 23) and also the general subject of life memberships. (Resolution 47)

The House directed The Council to appoint an ad hoc committee to study the relationship between the various state medical societies and the medical political action committees in the states. (Resolution 60 as amended)

The House approved the making of the Committee on Professional Liability a permanent Committee of the House. (Report of Reference Committee on Public and Professional Relations)

The House directed the Speaker to appoint a committee of the House to investigate remuneration of MSMS officers and report in 1969. Reference Report on Reports of Council and Officers)

The House urged the subcommittee on Para-Medical Education of the Education Liaison Committee to continue with its development of a program for the education of physician's assistants. (Resolution 48)

A House of Delegates Reference Committee reviewed the monograph "Where We Stand" and Resolution 65 pertaining thereto, and highly commended this document as a provocative and stimulating summarization of medical positions recommending that it be studied by all delegates and society officers as a basis for constructive dialogue and future deliberations. The House asked that the monograph be revised and updated yearly.

Eight Michigan physicians who have practiced 50 years and who were honored by the House of Delegates, pause in the hallway with MSMS President B. M. Harris, M.D., at far right. The five men in the front row with Dr. Harris, left to right, are: Lloyd Harvie, M.D., Saginaw; A. M. Giddings, M.D., Battle Creek; Fred O. Lepley, M.D., Grosse Pointe Woods; Karn C. Kerwell, M.D., Stephenson; Eldon C. Baumgarten, M.D., Grosse Pointe Woods; and Doctor Harris; and in the back row, left to right, Clyde Hasley, M.D., Detroit; M. S. Hurth, M.D., Lansing; and Milton D. Vokes, M.D., Detroit. Alfred C. Whittaker, M.D., Detroit, also was present to receive his pin but was not available for this photograph.

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY

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SEE PAGE 1371

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MICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 21 NOVEMBER 1968

AMONG THE IMPORTANT ARTICLES:

Warthin's Tumor Revisited
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Review of Some New Michigan Laws
Photos and Articles from Annual Session
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MICHIGAN MEDICINE

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COVER

The cover focuses attention on the efforts of the new Michigan Citizens Committee on Medical Manpower, which was called together October 16 by MSMS. See the article on 1371.

SPECIAL FEATURE

Special articles and photographs from the 1968 Annual Session are featured in this issue. See Pages 1357, 1358, 1359, 1360, 1361, the center blue pages, and other pages, too. Some photos appeared in the October News Extra and others will appear in the December journal.

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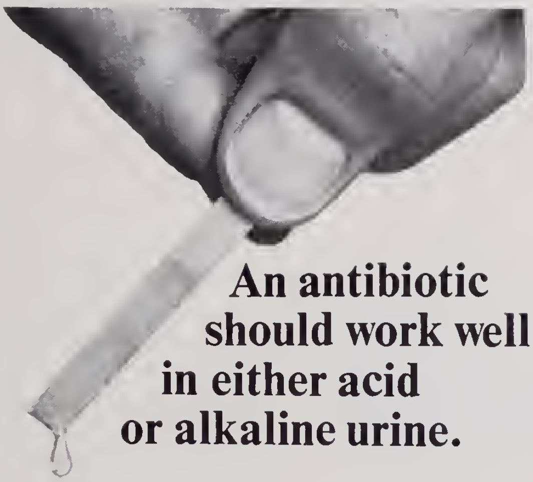

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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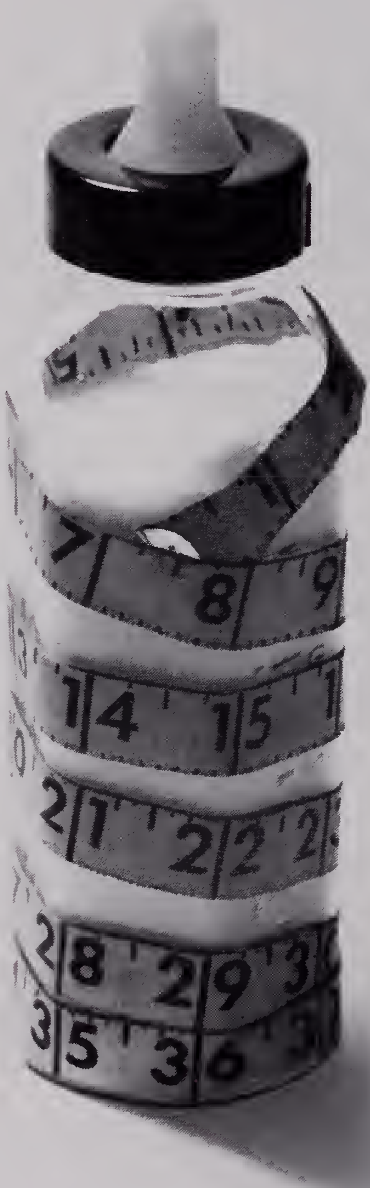

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*Lowe, Charles U., M. D., Mosovich, Luis L., M. D., and Pessin, Vivian, Ph. D.: Effects of Protein Level and Type of Heat Treatment of Milk Formulas on Growth and Maturation of Infants, J. Pediatrics 64:666-682 (May) 1964.

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BY JAMES J. LIGHTBODY, M.D.

MSMS PRESIDENT'S MESSAGE

Consider These Points . . .

(Editor's Note: At our suggestion, Doctor Lightbody has consented to using portions of his address to the 1968 House of Delegates for his President's Page in this issue.)

Let us hope that in the year ahead, that we, as physicians, will continue to give the best medical care possible to all segments of our population. The changes we are seeing in medical practice and hospitals are medical expressions of the same changes that are occurring in education, industry, government and in the entire social landscape.

The scientific progress of medicine, rising per diem costs in hospitals, and the mounting shortages of personnel to deliver high quality medical care are causing far-reaching changes in the whole spectrum of health service. The benefits of latest medical techniques can be delivered only through the inter-action of many specialists, and that in itself inevitably introduces an element of impersonality in the way the patient is treated.

It is fashionable in some quarters to level a constant barrage of criticism at physicians. Doctors are blamed for all the ills of society from juvenile delinquency to air pollution. This is both unjust, unfair and not based on the facts. The so-called "image" of the physician is still considered to be the highest and best of the professional and nonprofessional groups.

We should continue to support the activities of the state and local health departments as their activities many times overlap with our own health programs concerned with direct patient care.

One of the matters of great current interest to the Michigan State Medical Society is its relationship with the Negro physicians in this state, and this, I believe, is a major challenge and should be squarely met with the endorsement of a coordinated, bilateral program to improve our communications with the Detroit Medical Society and National Medical Association. Negroes constitute 11.4% of the nation's population, but have only 2.2% of the nation's physicians. According to a recent report released by the American Association of American Colleges, approximately 300 Negro students are expected to enter United States medical schools this fall. This represents a 50% increase over the situation five years ago.

The majority of Negro physicians have felt that the American Medical Association did not have a realistic motivated program to assure better care for Negro patients and did not fully comprehend the professional load that the Negro physicians of this country were carrying in attempting to take care of the great number of Negro patients. The difficulties that some Negro physicians have had in gaining hospital staff appointments is well-documented, but this is also true of some white physicians.

Specifically, I would suggest that state and county medical societies re-evaluate their interests in programs affecting the medical care of both the black and white poorer segments of our urban areas particularly, and make every effort to improve the professional relations of Negro physicians in all areas of health activities. I feel, however, that Negro physicians themselves should make a greater effort to participate in county and state medical societies' programs and activities so that we can eventually eliminate any racial inequities that may now exist.

Another matter of major concern is the care of the older people who are chronically ill. We must see the older patient as one of the great challenges in medicine rather than a candidate for custodial care. First class care for older people will lead to improved, preventive measures for younger ones. This frequently involves participation of county, state and federal programs, but this is going to be an expanding area of activity in the years ahead and the medical profession must concern itself in cooperating with and giving direction to public agencies.

The transition of our medical care system simply mirrors the transition of our whole society. Let us hope that this transition will bring some degree of stability—and perhaps, some degree of tranquility.

The new direction in which American medicine is going is not necessarily bad because it is different. William Osler wisely said: "The philosophies of one age become the absurdities of the next, and the foolishness of yesterday has become the wisdom of tomorrow."

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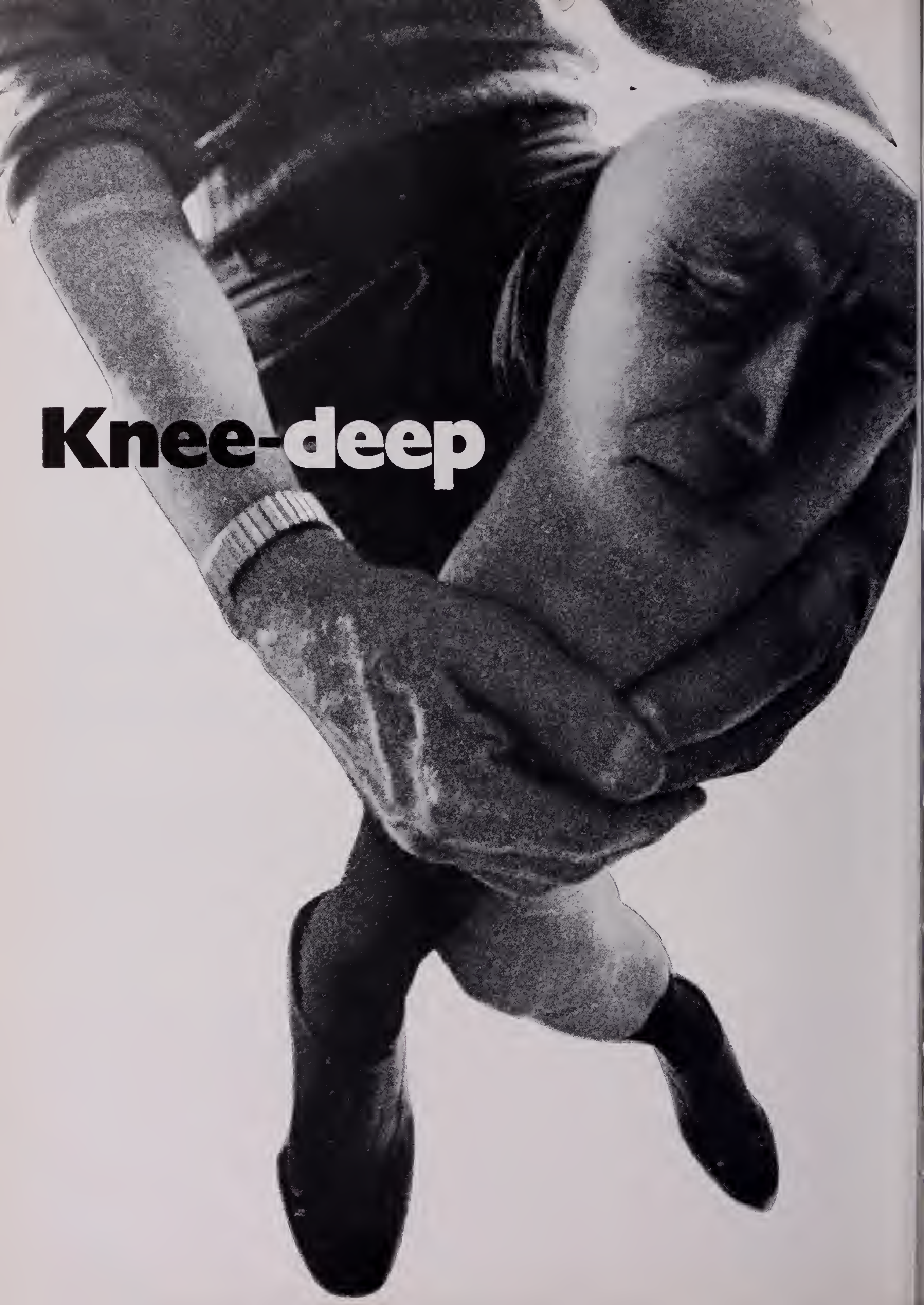

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in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006

Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

anticostive*
hematinic

60
Lederle
PERITINIC
Hematinic with Vitamins and Fecal Softener
TABLETS
LEDERLE LABORATORIES DIVISION

PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Easy on
the Budget...
Easy on
the Mother

Tablets & Elixir
For Iron Deficiency Anemia

FAMOUS
Fergon®
brand of FERROUS GLUCONATE

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

BRIGHTON HOSPITAL
A non-profit foundation
FOR ALCOHOLISM
Member, Michigan Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit
four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

Dilantin®
(diphenylhydantoin)

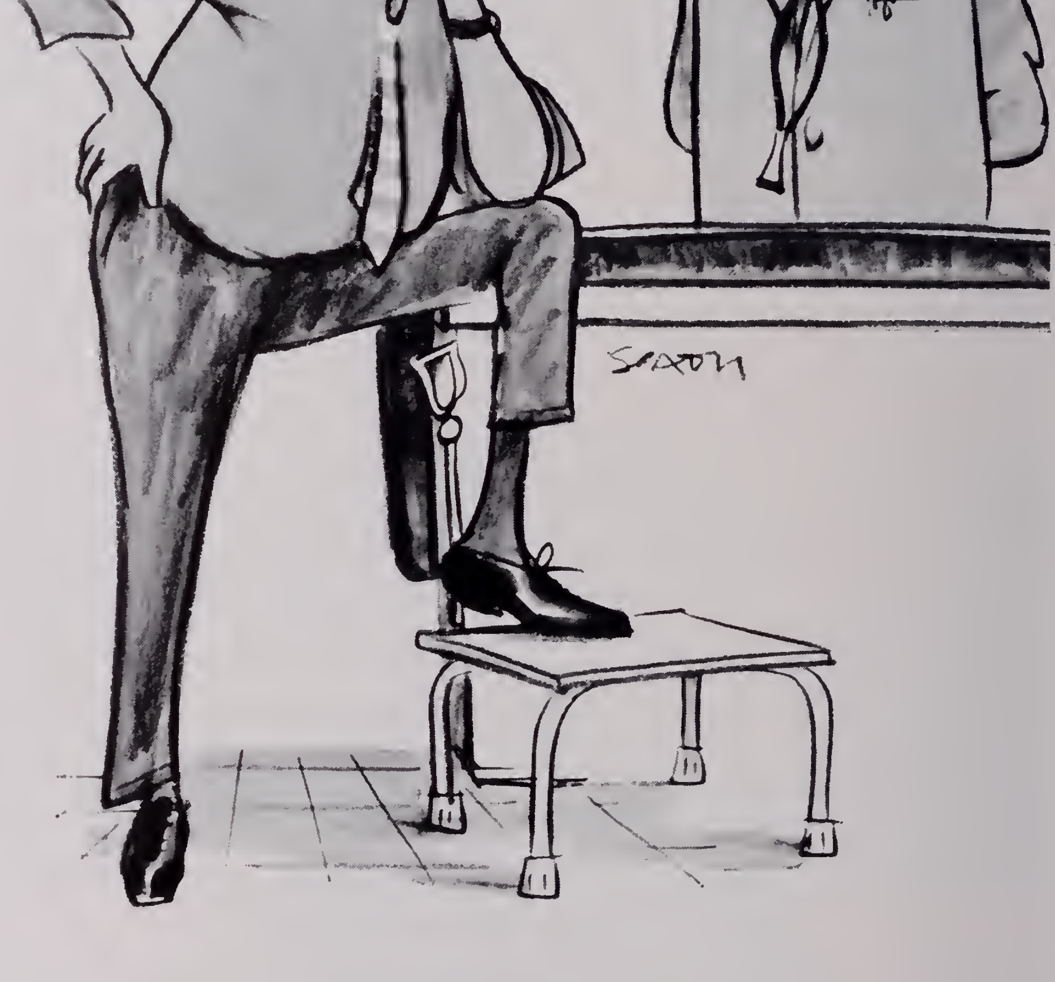
PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Say you saw it in Michigan Medicine

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

NOVAHISTINE LP
NOVAHISTINE SINGLET

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

"Breathing's a snap again," he said gingerly.
(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A-H-ROBINS

in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

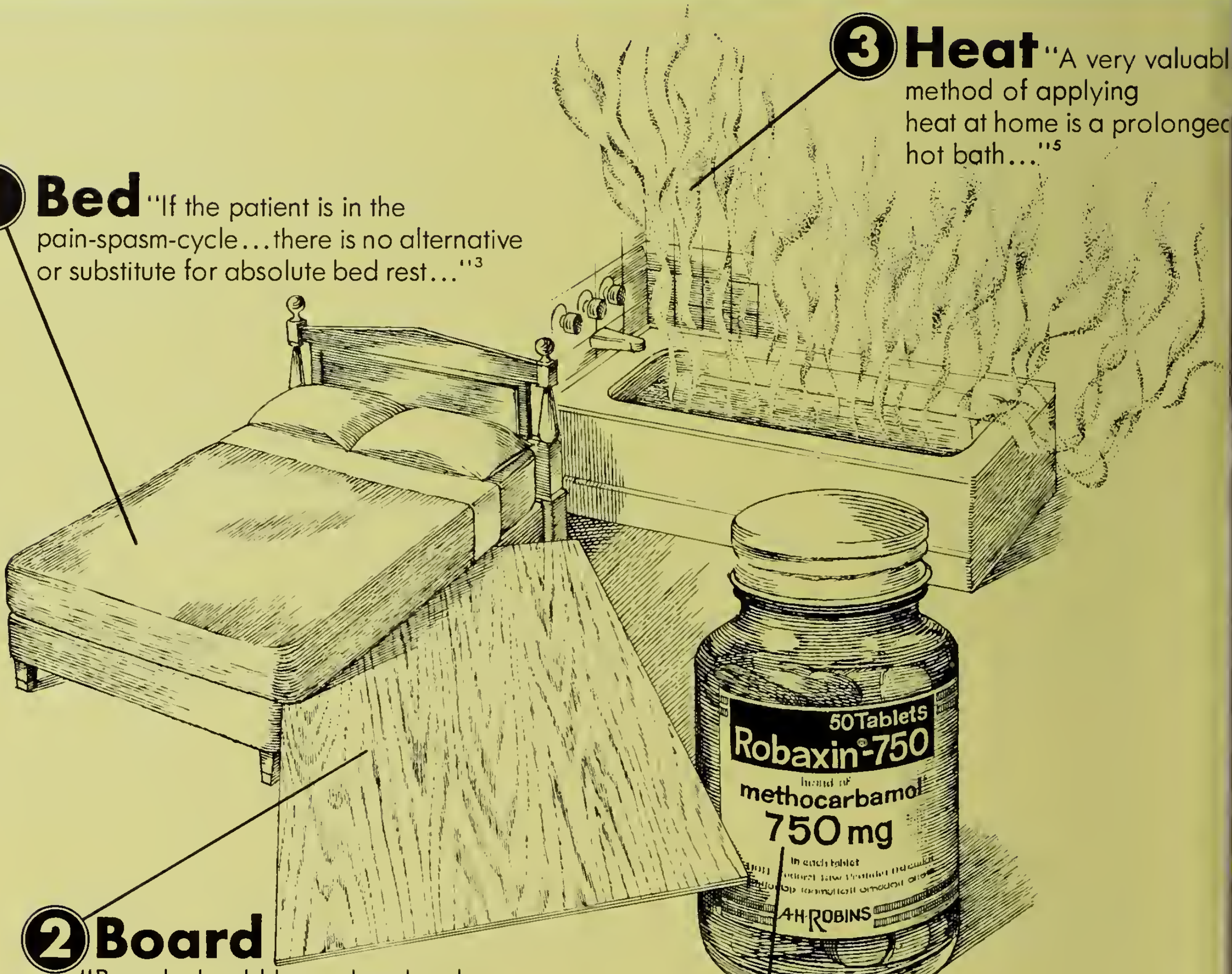
(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear
breathing on one tablet

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

③ Heat "A very valuabl method of applying heat at home is a prolonged hot bath..."[5]

④ Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220

In peptic ulcer:

the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

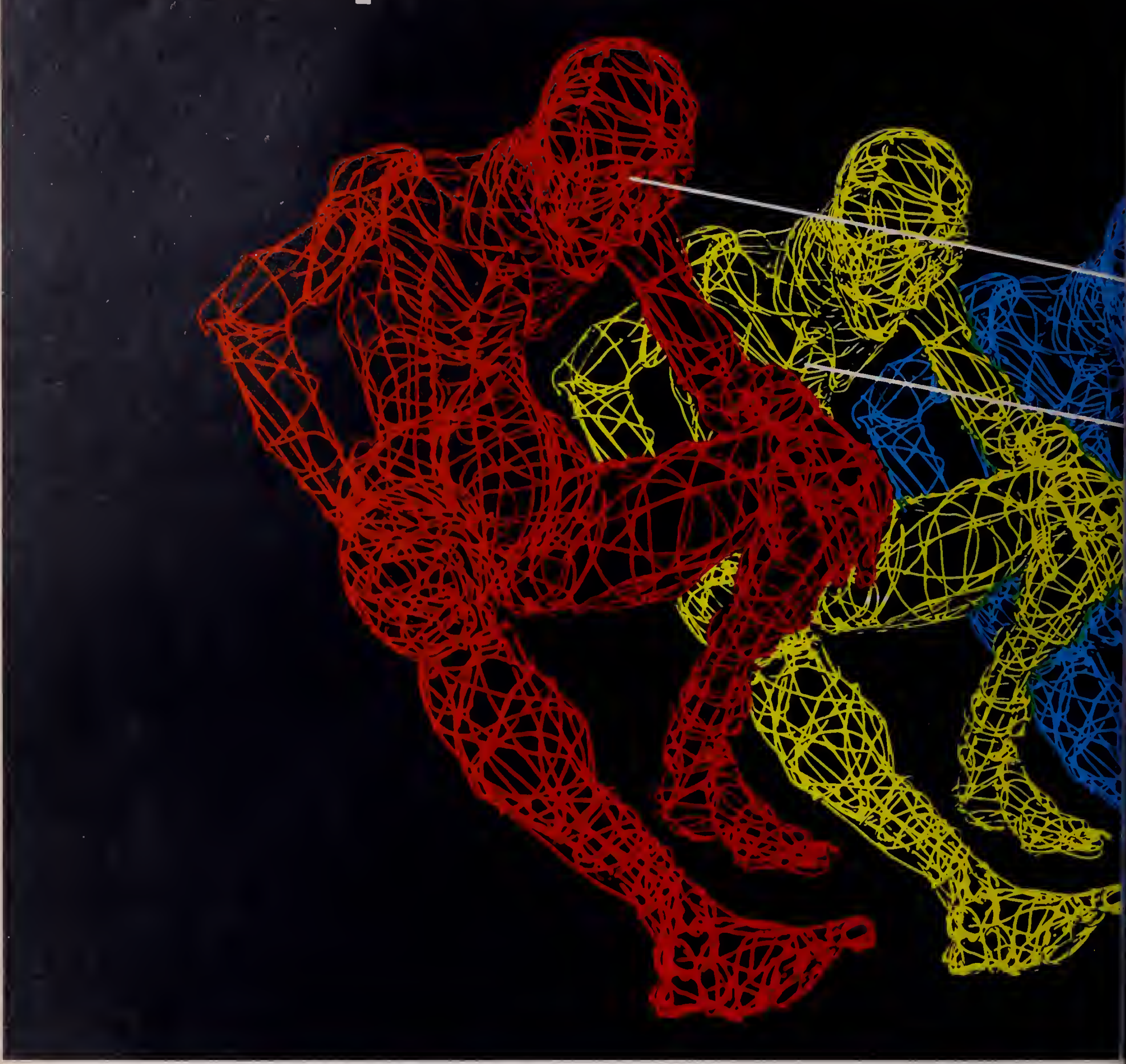
"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5	mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)		
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropri investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequ vitamin B_{12} therapy may result in hematologic remission but n rological progression. Adequate doses of vitamin B_{12} (parente or oral with potent intrinsic factor as in Trinsicon® [hemati concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resista may develop in some cases of pernicious anemia to the poten tion of absorption of physiological doses of vitamin B_{12}. If res ance occurs, parenteral therapy, or oral therapy with so-ca massive doses of vitamin B_{12}, may be necessary. No single r men fits all cases, and the status of the patient observec follow-up is the final criterion for adequacy of therapy. Peric

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are commended.

verse Reactions: In rare instances, iron in therapeutic doses oduces gastro-intestinal reactions, such as diarrhea or constition. Reducing the dose and administering it with meals will nimize these effects.

In extremely rare instances, skin rash suggesting allergy has lowed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after al administration of folic acid.

sage: One Pulvule twice a day. (Two Pulvules daily produce a andard response in the average uncomplicated case of perniDus anemia.)

w Supplied: Pulvules Trinsicon® (hematinic concentrate with rinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information
available to physicians
upon request.
Eli Lilly and Company,
Indianapolis, Indiana 46206.
801668

Lilly

"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

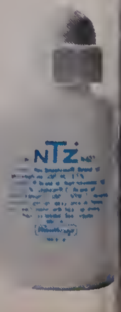
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

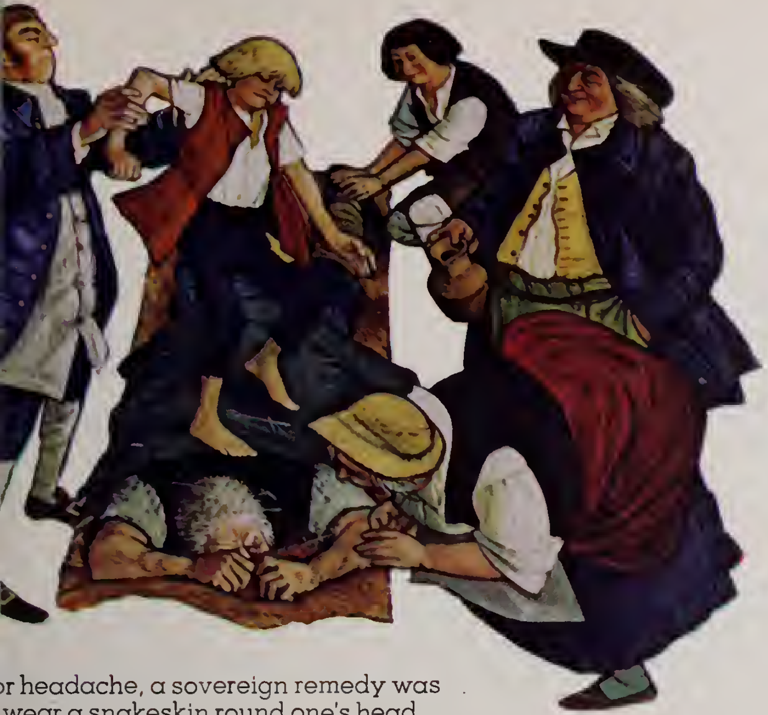
Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

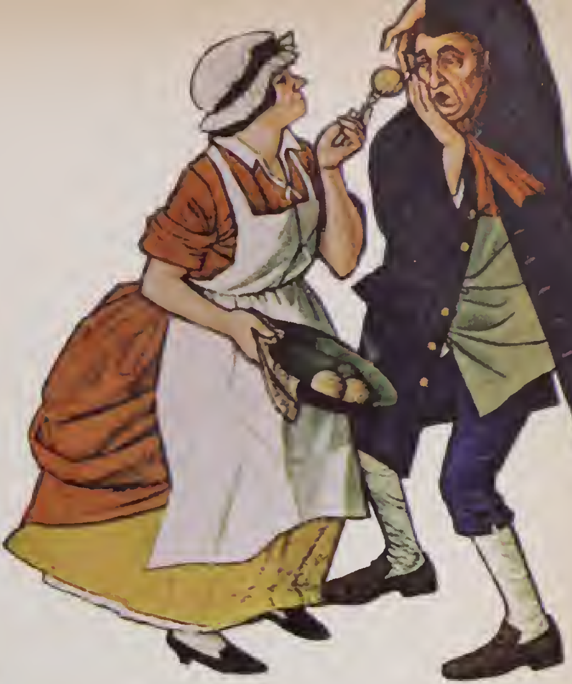
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016

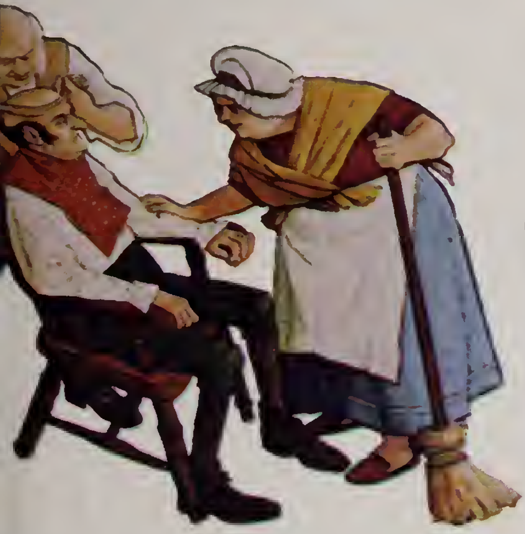
once-popular treatment for back pains
as to have the seventh son of a seventh son
and or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

r headache, a sovereign remedy was
wear a snakeskin round one's head.



A realistic approach to pain relief

Empirin®

Compound with Codeine
Phosphate gr. 1/2 No. 3

ach tablet contains:
odeine Phosphate gr. 1/2 (Warning—
ay be habit forming), Phenacetin gr. 2 1/2,
spirin gr. 3 1/2, Caffeine gr. 1/2.

eeps the promise
f pain relief

W. & Co.' narcotic products are
ass "B", and as such are available on oral
escription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Muscle in Spasm

and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HOD
CARMEL
DELICATESSEN
CATERING

A littl

Just one 50 or 100
tablet in the morni
can work a long
diuretic day in ede
and hypertension.

HY-6060

lygroton® can work a long day too
lorthalidone

it's because of its prolonged
ion, which usually provides
ooth diuretic activity
oughout the day. And
e-a-day dosage means few
lets to take and few tablets
pay for in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

lygroton
lorthalidone in edema and hypertension

Geigy

CARMEL
CATERING

in edema and hypertension

A little Hygroton® can work a long da

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated whe chlorthalidone is combined with ba biturates, narcotics or alcohol, apla anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rash urticaria, purpura, necrotizing angi acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, pare thesia, and photosensitization.

Average Dosage: 50 or 100 mg. wit breakfast daily or 100 mg. every ot day.

Availability: White, single-scored t lets of 100 mg. and aqua tablets of mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Is it depression?

He says "It's my stomach..."

...but his other symptoms:

functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt

strongly suggest

an underlying depression.

---

when the diagnosis is depression

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Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

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Warthin's Tumor Revisited

ABSTRACT: Warthin's tumor is a tubulo-papillary-cystic oncocytoma arising from parotid duct cells enclaved in lymph nodes external to or within the parotid gland. It is an asymptomatic completely benign tumor seen in middle-aged Caucasian males, representing from six to 10% of all parotid tumors. The tumor is readily removed surgically. Descriptive pathological features are reviewed.

BY MERRILL A. COHEN, M.D.
JOHN G. BATSAKIS, M.D.
BOTH OF ANN ARBOR

It is almost 40 years since A. S. Warthin[1] described and presented for the first time in the American literature the tumor, papillary cystadenoma lymphomatosum. Since then, and in numerous papers, the lesion, either by form of tribute or through facility, has been commonly called Warthin's tumor.

Many of the ensuing reports were by pathologists who, perhaps piqued by the unusual association of lymphoid and epithelial tissue displayed by the tumor, presented a variety of histogenetic theories. Two studies stand out amongst the several hundred recorded in the literature: Thompson and Bryant's[2] elucidation of the pathogenesis of the lesion and the review of the clinical features by Chaudhry and Gorlin.[3]

The present report, 40, 20 and 10 years after the three aforementioned publications, is a contemporary compendium of the clinical, pathological, experimental and nosological features of this unique tumor.

Histogenesis and Nosology

Early reports included many hypotheses for the development of the Warthin tumor.[2-4] The currently accepted theory is an origin from heterotopic salivary gland tissue within lymph nodes external to or within the parotid gland.

Thompson and Bryant[2] studied the embryonic development of the salivary glands and found that whereas the submaxillary and sublingual glands develop as compact entities, the parotid gland develops in a loose arrangement containing aggregates of lymphoid tissue, and encapsulation occurs late in ontogeny. Thus, lymph nodes become enclosed with the parotid gland, and salivary ducts and acini become included in these nodes, as well as in nodes outside the definitive gland which were excluded by the formation of the capsule. It is from these ductal epithelial elements, incorporated in lymphoid tissue outside and within the parotid capsule, that the tumors arise. The finding of ductal inclusions in lymph nodes in or near the parotid, the occasional multicentricity of Warthin's tumor in several apparently uninvolved lymph nodes, and the relatively undisturbed lymph nodal architecture seen about tumors removed at an early stage of their formation are features supporting this thesis (Figures 1-4).[5, 6]

The cause of the oxyphilic alteration in the epithelial elements is not known.

Whether or not the oxyphilic adenoma, the so-called oncocytoma, is a variant is also not known. This tumor, also composed of oxyphilic, finely granular epithelial cells may have a solid or medullary pattern, or be tubulo-papillary-cystic. It **does not** have a lymphoid component. Its origin is from salivary ductal epithelium, and the ultrastructure of the epithelium is identical to the cells of the Warthin's tumor.[7] In the Warthin's tumors studied by Thompson and Bryant,[2] masses of polyhedral oxyphilic epithelial cells were noted, similar in pattern to the medullary oncocytoma, and so for classification purposes, Warthin's tumor may be regarded as an oncocytoma of tubulo-papillary-cystic type arising from parotid duct cells enclaved in lymph nodes.[5]

Clinical Features

Although Warthin's tumor has been reported as occurring in a wide age span ($2\frac{1}{2}$[8] - 92 years[9]), 82% are found in patients between 41 and 70 years of age (avg. = 55.6 years[3]). There is a decided (5 to 1) male predominance.[3] Only one case has been reported in a Negro.

The tumor is asymptomatic; only 10% of patients present with complaints other than a symptomless mass, those complaints being pain, pressure sensations or rapid increase in size of the tumor. Facial nerve weakness has been reported only once. The lack of discomfort accounts for the

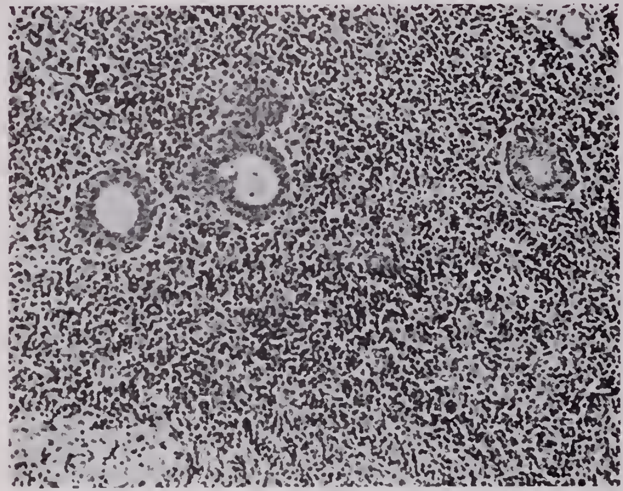

FIGURE 1

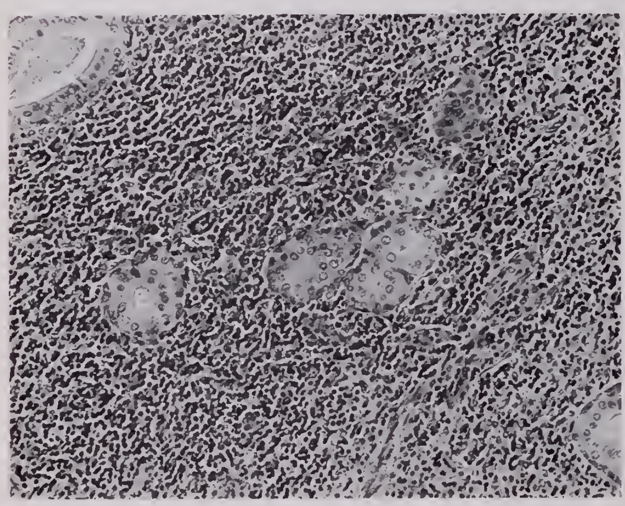

FIGURE 2

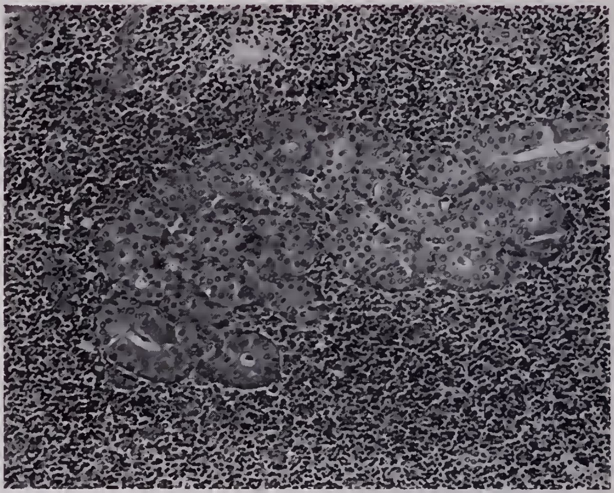

FIGURE 3

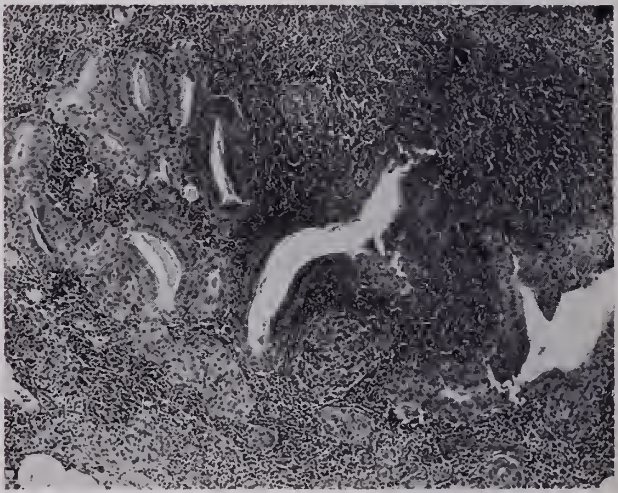

FIGURE 4

Figures 1 through 4 are representative of the ductal changes occurring in the progressive genesis of a Warthin's tumor. Figure I is the earliest stage of development with ductal elements enclaved in lymphoid tissue. This is followed by progressive hyperplasia (Figures 2-3) and then by dilation and intra-cystic papillation of the included ducts. Continued development of the lesion leads to the appearance illustrated in Figure 5.

relatively long duration before diagnosis. The average duration is three years and reports give a range of two weeks to 30 years.[3]

Despite reports of the tumor occurring in sites other than the parotid gland or its environs, Warthin's tumor is best considered as a lesion of the parotid gland, where it represents 6%[3] to 10%[10] of all parotid gland tumors; second in frequency of benign tumors only to the mixed tumors. It occurs most often in the lower pole of the gland, next to the angle of the mandible.[3] Because of the pathogenetic relationship described above, the tumor may arise in lymph nodes superficial or medial to the parotid gland. In 29 instances, the tumors were bilateral.[11]

Baum and Perzik[11] and Martin and Ehrlich[12] pointing out the intimate relationship of the tail of the parotid gland with the submaxillary gland, doubt the validity of the latter being reported as a primary site. A few unquestionably Warthin tumors have been noted in the lower lip[13, 14] and the palate[15] but doubts exist over the credibility of reported tumors in the oropharynx, hypopharynx, posterior nasal space, larynx, and thyroid gland.

The tumor is well-defined, soft or fluctuant or, if deep within the gland, firm to palpation. The average size is given as 3.6 cm. with a range of 1 to 8.5 cm. at the time of surgical removal.[3]

The preliminary clinical impression is mixed tumor when presenting in the salivary gland; branchial cyst if the presentation is below the gland; or lymphoma or lymphadenitis if the presenting site is lower in the neck.

Sialography is reportedly of little diagnostic value,[3, 12] since the displacement of the ducts indicates only a "space-occupying" mass. Aspiration biopsy and staining of the air-dried smears of the aspirates with May-Grunwald-Giemsa stain may permit a correct diagnosis in up to 83% of the cases,[16] but repeated biopsy may be required, and, in most cases, the patient will come to surgery anyway. The aspiration technique, however, has merit if the patient is opposed to surgical removal of the mass and malignancy needs to be excluded.

Treatment and Natural History

The Warthin tumor is particularly amenable to surgical removal. It is usually superficially placed,[3] and the facial nerve is rarely involved by the tumor. While well-defined, the tumor does not usually shell out easily, and this factor, with the desire not to spill the cyst contents, requires removal of adjacent gland.[11] Radiation may decrease the size of the lesion, but does not effect its regression[17, 18] and is not a substitute for surgical removal.

Recurrence rates are difficult to compute from reports because of insufficient follow-up. Six of 49 tumors encountered at Memorial Hospital manifested recurrence.[19] Incomplete excision, operative spillage of tumor contents, or more likely, growth from a new focus are held responsible. Multicentricity at first excision has been repeatedly noted.

Earlier reports of malignant Warthin's tumor have been refuted by many authors.[2, 3, 19, 20, 21] A case of **purported** malignant transformation with metastases has been reported by Ruebner and Bramhall.[20] However, an occult metastasizing thyroid carcinoma may be a more likely alternative. Two recent case reports, [21, 22] are more convincing. The patients, in both instances, had received irradiation to the neck, eight and 13 years earlier. In view of the fact that these two cases, of almost 600 cases of Warthin's tumor reported in the literature, are the only reasonably acceptable examples of malignancy certainly speaks for a **spontaneous** malignant propensity of such low order as to be non-existent. Involvement of the lymphoid component of the tumor by leukemia and by Hodgkin's disease has been reported.

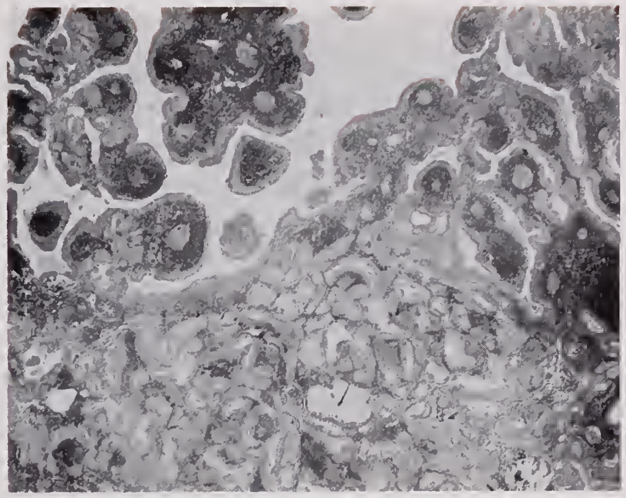
Figure 5: Fully developed papillary cystadenoma lymphomatosum in parotid gland.

Gross and Microscopic Features

The tumor is encapsulated and round or oval with a smooth or lobulated surface. It is usually cystic or semi-solid and compressible. A fluid of variable character but usually mucoid and brown-tinged, exudes from the cut surface. On section, multiple irregular cystic spaces with papillary projections are seen (Figure 5). Solid areas are grey and may manifest many small white nodules representing lymphoid follicles.

COHEN

CO-AUTHORS

Both Doctors Cohen and Batsakis are associated with the Department of Pathology, University of Michigan Medical School.

BATSAKIS

Microscopically, an epithelium having a tubulopapillary-cystic pattern is within lymphoid tissue or a lymph node. The latter has sinuses, lymph follicles, and usually, an embracing connective tissue capsule. Lymph node architecture may be so compressed and distorted by the epithelial components that sinuses may not be readily evident, but follicles are usually seen.

The epithelium is a double layer of oxyphilic, finely granular cells; an inner layer of round, cuboidal or polygonal cells and an outer zone of non-ciliated, tall columnar or clavate cells. The nuclei of the inner cells are vesicular, while those of the outer layer are usually pyknotic and situated uniformly toward the luminal surface. Not all the cells have the same intensity of staining with eosin; some are pale and distinctly granular while others are intensely red and homogeneous. Mucus or goblet cells may be interspersed in the epithelial layer. A piling-up of epithelium or focal areas of squamous metaplasia occasionally may be seen. A fine basement membrane separates the epithelium from the lymphoid tissue.

Phosphotungstic acid-hematoxylin stains on paraffin embedded tumors demonstrate numerous fine, blue-black granules (mitochondria[23]) in the cytoplasm of both cell types in the epithelial layer. Positive histochemical reactions for phosphatases, esterase and various mitochondrial enzymes are demonstrable, but not in significantly greater degree than in normal parotid gland ducts, though certain qualitative differences exist.

Ultrastructural examination of the epithelial cell cytoplasm finds it packed with mitochondria in both apical and basal areas. Many are in groups, enlarged, and manifest increased numbers of cristae.[24] The staining variation noted under the light microscope correlates with the numbers of mitochondria in the cells.[25]

The fluid within the cystic spaces of the tumor and into which papillae project has a homogeneous or finely granular eosinophilic appearance.

Summary

The papillary cystadenoma lymphomatosum (adenolymphoma), or Warthin's tumor, is a benign tumor of the parotid gland or its immediate environs. It is a neoplastic growth of cells of ductal inclusions in lymph nodes in or adjacent to the parotid gland and this accounts for its biphasic (epithelial and lymphoid) structure. The tumor is usually asymptomatic and occurs predominantly in males between the ages of 40 and 70 years. Surgical removal is the only acceptable modality of treatment.

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MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING SEPTEMBER 28, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	11	21	275	940
Whooping Cough	36	71	357	815
Diphtheria	0	0	0	1
Mumps	133	239	13251	13202
Scarlet Fever & Strep Sore Throat	359	360	7652	10188
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	2	0	3
Hepatitis	194	154	1617	1464
Salmonellosis (Other than S. typhi)	34	58	489	414
Typhoid Fever (S. typhi)	0	1	0	7
Shigellosis	34	17	208	317
Aseptic Meningitis	130	10	184	48
Encephalitis	13	3	69	86
Meningococcic Meningitis	6	5	74	58
Influenzal Meningitis	5	2	42	43
Tuberculosis	236	217	2122	2210
Syphilis	377	383	4048	4203
Gonorrhea	1496	1518	13384	12738

MICHIGAN
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HEALTH

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Dietary Fat Restrictions and Atromid Therapy In Patients With Type II Familial Hyperlipoproteinemia

BY SHAFEEK S. SANBAR, M.D., PH.D.
ANDREW J. ZWEIFLER, M.D.
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ALL OF ANN ARBOR

The three co-authors, Doctors Sanbar, Zweifler and Conway are all associated with the Department of Internal Medicine, University of Michigan Medical School.

The observation by Oliver[1-2] that Atromid* (clofibrate + androsterone) diminishes the concentration of serum cholesterol and triglyceride in patients with hypercholesterolemia and ischemic heart disease has been repeatedly confirmed.[3-5] Substantial reductions in serum lipids occur in patients with hypertriglyceridemia associated with an increased plasma concentration of very low density beta-lipoproteins.[4-7] On the other hand, patients with essential hypercholesterolemia or hyperbeta-lipoproteinemia, referred to recently as type II familial hyperlipoproteinemia,[8] in whom serum triglyceride concentrations are generally within the normal range respond relatively poorly to Atromid therapy alone.[4-7]

The following study depicts the effects of dietary fat restriction and Atromid therapy in 15 patients with type II familial hyperlipoproteinemia. Results show that the combination of diet and drug therapy produces substantial reductions in serum cholesterol in 60% of the patients.

Materials And Methods

Thirteen female and two male patients with type II hyperlipoproteinemia were studied (Table I). Their ages ranged from 6 to 58 years, and they all were normoglyceridemic. The average serum cholesterol concentration on no treatment and after a 12- to 16-hour fast was above 300 mg% on 2 successive determinations obtained two to four weeks apart. Paper electrophoresis of serum lipoproteins according to the modification of Lees and Hatch[9] demonstrated hyper-beta-lipoproteinemia. All patients had positive family history of hypercholesterolemia, and none of them showed either clinically or by laboratory tests evidence of a known cause for the hypercholesterolemia. Two patients (M.D. and D.D.) were mildly obese and two others (G.C. and P.A.) had diabetic relatives.

All patients were instructed in a diet with a total calorie content of 30-35 calories per kg body weight of which 15-20 per cent was fat, ⅔ unsaturated and low in cholesterol, 20 per cent was protein, and 60-65 per cent was carbohydrate. The patients were seen at monthly intervals in the fasting state for collection of blood and clinic evaluation. After a two-month-trial on diet alone, 1-2 g Atromid were given daily for two months, after which Atromid was withdrawn for two more months while the patients remained on the diet.

Fasting blood samples were analyzed for serum cholesterol and triglyceride by the methods of Connerty and co-workers[10] and Van Handel and Zilversmit,[11] respectively.

Results

Dietary fat restriction for two months produced only a slight decrease in the overall mean serum cholesterol concentration from pretreatment level (Table I), but five patients appeared to have reductions greater than 10%.

Atromid in addition to the diet produced further reductions of serum cholesterol in most of the patients. In nine of them, so-called "responders," serum cholesterol fell more than 15% after addition of Atromid. The mean serum cholesterol of the responders during "diet + Atromid" was respectively 26% and 21% below the mean values of "pretreatment" and "diet alone." Withdrawal of Atromid without change in diet resulted in a return of mean serum cholesterol to or towards the value observed initially on diet alone. In the remaining six patients, so-called "non-responders," there were only slight changes in serum cholesterol after diet and drug therapy. Also noted in Table I are the overall mean changes in serum cholesterol.

---

*Kindly supplied by the Ayerst Company.

TABLE I

Response of 15 Type II Hyperlipoproteinemic Patients To Therapy With A Low Fat Diet And Atromid*

Name	Age in yrs.	Sex	Triglyceride	Serum cholesterol in mg% Pretreatment	Diet Alone 2 months	Diet + Atromid 2 months	Diet only 2 months
RESPONDERS							
V.F.	6	F	81	423	374**	245	308
C.C.	12	F	148	333	338	272	334
P.D.	14	F	156	420	451	362	378
M.L.	23	F	84	385	405	318	360
E.F.	39	M	91	386	363	232	290
G.C.	40	F	122	453	452	373	377
P.A.	44	F	135	375	286**	264	326
L.Dr.	46	F	139	493	417**	303	358
A.T.	56	F	115	585	547	486	545
Mean of responders			119	428	404	317	364
+ S.E.M.			14	25	25	27	25
NON-RESPONDERS							
L.C.	9	F	130	349	340	330	370
D.D.	16	F	118	650	607	696	600
J.T.	22	F	127	408	371	361	366
M.D.	36	F	140	384	324**	390	376
H.R.	47	M	170	365	326**	315	350
P.S.	58	F	89	460	443	393	427
Mean of non-responders			129	436	402	414	415
+ S.E.M.			11	46	45	58	38
Overall Mean			123	431	403	356	384
+ S.E.M.			7	23	22	30	22

* Dose of Atromid: 1 g/day for V.F., 1.5 g/day for C.C. and L.C., and 2 g/day for the rest of the patients.
** Greater than 10% decrease from pretreatment value.

Discussion

These data show that dietary fat restriction alone produces little change in serum cholesterol of patients with type II hyperlipoproteinema. On the other hand, Atromid in addition to the diet produces a substantial decrease in serum cholesterol in nine out of 15 patients studied; the remaining six patients have responded either poorly or not at all.

Earlier reports have indicated greater resistance of type II hyperlipoproteinemia patients to treatment with Atromid than we find here. Strisower[5] reported that in only two out of seven patients with this disorder did Atromid induce a substantial decrease in serum lipids and beta-lipoproteins. Howard and co-workers[4] also studied seven patients with this disorder. In two female patients Atromid produced a marked reduction in serum cholesterol, whereas in only one of five male patients was there a moderate response. Jepson and James[6] reported that Atromid therapy in 7 patients with idiopathic hypercholesterolemic xanthomatosis (presumably type II hyperlipoproteinemia) produced only a mean decrease of 9% in serum cholesterol, with a maximum response of 12.9%. The chief difference between the above three studies and our own is the very low fat diet which is mostly unsaturated. This may well be the reason for the greater responses in our patients.

Nevertheless, 40% of our patients with type II hyperlipoproteinemia responded either poorly or not at all to the combination for unknown reasons. One possibility is that 2 months of combined therapy is not long enough. Whether or not prolonged therapy with this combination may be of benefit to some of the "non-responders" is a matter for further study.

Summary

In patients with type II familial hyperlipoproteinemia dietary fat restriction for two months produced no significant reduction in concentration of serum cholesterol. Addition of Atromid (mixture of ethyl p-chlorophenoxyisobutyrate and androsterone) to the diet for two months produced greater than 20 per cent mean decrease in serum cholesterol in 60 per cent of the patients. Withdrawal of Atromid therapy without change in the diet resulted in a return of serum cholesterol to or towards the value observed initially on diet alone.

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Clinical Experience With Haldol (Haloperidol) In Chronic Schizophrenics

ABSTRACT: Haldol (Haloperidol), a non-phenothiazine tranquilizer revealed its effectiveness on chronic schizophrenics who are withdrawn and hostile. The daily maintenance dosage varied from eight to twelve milligrams. Fifty percent of the patients developed neuromuscular reactions but they were adequately controlled with Trihexphenidyl (Artane). No hypo-tensive reaction, blood dyscrasias, liver dysfunction, photo-sensitivity and convulsions were observed in this study.

BY B. S. YUN, M.D.
OWOSSO

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Haldol (Haloperidol), a butyrophenone derivative is a non-phenothiazine tranquilizer and has been used in Europe for the past ten years, although it is a new drug in the United States. This study was designed to investigate the clinical effectiveness in Schizophrenics.

Subjects

The subjects for this study were twelve female hospitalized patients who were on the disturbed ward and under close supervision because of their unpredictable behavior. These patients were chronic schizophrenics who were withdrawn, agitated, aggressive, hostile, delusional, hallucinating patients who were refractory to previous drug therapy, mostly phenothiazines, and electro-convulsive therapy. Their ages ranged from 19 to 58 years. Their period of hospitalization varied from 4 to 25 years.

Methods

Preparation:

All previous medications were discontinued for three days before initial doses of Haldol were administered.

To rule out blood dyscrasias, kidney dysfunction and liver dysfunction, the following laboratory tests were conducted: complete blood count, urinalysis, liver function tests, e.g., total protein, cholesterol, serum bilirubin, transaminase (SGOT), alkaline phosphatase, thymol turbidity. These tests were performed before starting treatment and were repeated bi-weekly for three months.

Temperature, pulse, respiration, blood pressure and weight were taken three times weekly during the period of treatment.

Dosage:

Initial dosage of Haldol was 0.5 mgs. three times a day for five days. It was then increased to 1.0 mgs. four times a day for five days, and then 2.0 mgs. four times a day for three days. Thereafter, according to clinical response to the drug the dose in some cases was increased up to 20 mgs. daily, for a period of three months.

Maintenance dosage in our experience ranged from 8 mgs. to 12 mgs. per day.

Performance Evaluation:

The patients on the ward were observed daily by the physicians, registered nurses, and psychiatric attendant nurses, who then rated the results after the three months of drug therapy.

Results

Clinical improvement was divided into five categories: Remarkable improvement (+++); moderate improvement (++); slight improvement (+); unchanged (O); condition exacerbated (—).

The results of the drug therapy are indicated in Table I.

TABLE I

Ratings	No. of Patients	
Remarkable improvement (+++)	2	50%
Moderate improvement (++)	3	
Slight improvement (+)	1	
Unchanged (0)	3	
Condition exacerbated (—)	3	

Target symptoms:

It was our clinical observation that the drug was most effective on improving personal appearance, contact with reality, cooperation, sociability and eating habits, and on reducing hostility, paranoid ideation, and auditory hallucinations (Table II).

TABLE II

Target symptoms	No. of cases improved
Personal appearance	3
Hostility	2
Contact with reality	2
Paranoid ideation	2
Cooperation	1
Sociability	1
Auditory hallucinations	1
Eating habits	1

Among these patients who have shown improvement:

Patient E:

This patient had been continuously hospitalized for the past 25 years, mostly on the disturbed ward. She was extremely paranoid, hostile, destructive, and assaultive to nurses.

She has shown moderate improvement, become more cooperative, sociable, and is no longer delusional after the three month period of drug therapy. She was transferred to a better ward where she could enjoy more freedom with fewer restrictions. The patient has been performing well in occupational therapy and has started to work regularly, and is attending typing classes. She started having home visits up to two weeks duration, unusual for many years.

Patient C:

This patient was hospitalized continuously for the past six years and has been quite paranoid with religious preoccupation, and complained of voices annoying her constantly. In addition she was quite manneristic.

She has shown moderate improvement, no longer has delusions, and voices are gradually disappearing. She was transferred to the better ward and allowed to have week-end home visits on a regular basis.

Patient L:

She has been schizophrenic for the past five years, delusional, and preoccupied with sexual ideas. She would giggle and laugh with silly facial expression at times.

She has shown marked improvement and started to have week-end visits at the end of three month's drug therapy. Eventually she was transferred to the better ward. She has done well in occupational therapy and has shown more initiative in social interaction. After having a 30 day successful home visit she went home on convalescent status recently.

Side Effects

Nausea and vomiting: 58% of the patients had nausea and vomiting during the initial three days with the dosage of 0.5 mgs. administered three times a day. This side effect was controlled with anti-spasmodics (e.g. Donnatal). It was noted as the dosage was gradually increased the nausea and vomiting did not recur.

Neuromuscular reactions: 50% of the patients developed neuromuscular reactions: tremor (3 cases), muscular rigidity (2 cases), and akathisia (1 case).

TABLE III

Side effects	No. of cases	
Nausea and vomiting	7	58%
Tremor	3	50%
Muscular rigidity	2	
Akathisia	1	

Correlation of dosage and neuromuscular reactions revealed their presence at dosage levels as low as 4 mgs. per day. In some cases neuromuscular reactions did not occur until the dosage reached 16 mgs. per day. Neuromuscular reactions in all cases were controlled adequately by administering trihexyphenidyl (Artane) with the daily oral dosage varying between 2 mgs. three times a day and 2 mgs. four times a day.

Summary

Haldol (Haloperidol) appears to be a potent anti-psychotic tranquilizing drug, especially useful in treating chronic Schizophrenics who are not amenable to the phenothiazine group of drugs.

It is effective in improving personal appearance, contact with reality, sociability, eating habits, auditory hallucinations, and reducing hostility and paranoid ideation.

Maintenance dosage varied from 8 to 12 mgs. per day in the patients in this study.

YUN

CO-AUTHORS

Doctor Yun, formerly, was chief psychiatrist of the female receiving unit, of Kalamazoo State Hospital, presently Director of the Shiawassee County Community Mental Health Center, Owosso, Michigan; Doctor Banner is a staff psychiatrist, and Doctor Overbey is assistant superintendent of Kalamazoo State Hospital, Kalamazoo, Michigan.

BANNER

In regard to side effects, 58% of the patients developed nausea and vomiting, but as dosage was increased gradually these symptoms disappeared.

50% of the patients developed neuromuscular reactions but these were adequately controlled with trihexyphenidyl (Artane).

Hypotension, skin reactions, blood dyscrasias, liver dysfunction, and convulsions did not appear in any cases.

Undesirable weight gain was no problem with Haldol.

Acknowledgement

We express our gratitude to the McNeil Laboratories for their supply of the drug, and the nursing staff of the Female Receiving Unit, the Van Deusen Building, Pharmacy, and the Clinical Pathological Laboratory of the Kalamazoo State Hospital for their assistance in this study.

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Sex Education Books Suggested

(Editor's Note: The following article includes an excellent bibliography to help physicians, educators, and others in their current efforts to work with Michigan communities, schools, PTA units, and others in the broad field of family life education and sex education).

The author, James S. Feurig, M.D., is medical director for the Health Center at Michigan State University and team physician for the Spartans.

The question of who should teach sex education to children and youth has always been a suppressed dilemma. It appears that the most effective program will involve comprehensive and well-organized teaching in the areas of: home, school and church.

The subject must be approached from the standpoints of: biology, heritage, morality and emotional pressure. A completely effective educational process will result in a fusion of these facets to the extent that the student will have a total concept of exactly what sex is.

It is too late to initially start sex education at the college level. This is something which has to be a part of child development and must be presented in the curriculum of elementary and secondary education. It should ideally be an extremely well-planned and step educational process which starts in kindergarten and progresses through high school. The teachers must have special training and be most competent. This should never be an area to "relegate" the teaching.

If the school, home, and church infinitely work together, the sex education program will be a very effective means to relate to young people the true meaning of sex and all of its implications.

Some selected reading sources which are apropos to the concerned age groups in this area are as follows:

For Children:

What is a Human. Alexenburg, Benefic Press, Chicago, 1964; *The Baby.* Ets, Marie Hall, Viking Press, 1953; *The Wonderful Story of You.* Gruenburg, Sidonie; *The Wonderful Story of How You Were Born.* Gruenburg, Sidonie; *And Now, Miguel.* Krumgold, Joseph. Crowell, 1953; *A Story About You.* Lerrigo, Dutton, $3.50; *The Question and Answer Book About the Human Body.* McGovern, Ann. Random; *Wonders of the Human Body.* Ravelli, Anthony. 1954; *How Your Body Works.* Schneider, Herman and Nina, Young Scott (10-14); *From Egg to Chick.* Selsam, Millicent; *All About Eggs.* Selsam, Millicent, Young Scott. $2.50; *Gypsy.* Seredy, Kate. Viking.

For Youth:

A Is For Anatomy. Cosgrove, Margaret. Dodd, 1965, $2.99; *Growing Up, How We Become Alive, Are Born, and Grow.* de Schweinitz, Karl MacMillan, 1963. $3.24; *Love and Sex In Plain Language.* Johnson, Eric. Lippincott. 1965; *How Life Begins,* Power, Jules. Simon and Schuster. $3.95; *Animals As Parents.* Selsam, Millicent. Morrow. $2.95.

What Is This Thing Called Health Education?

BY WM. H. CARLYON, PH.D.
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The low regard that many teachers and administrators have for health education is astonishing. This may seem paradoxical in light of the fact that health has been considered as a cardinal principle of education since 1918. But, health, like motherhood, is easy to be for without really understanding what is involved. In practice there often appears to be little relationship between our expressed devotion to the health of the school child and what we actually do about it.

Part of the problem is semantic. The term education itself refers to a complex abstraction about which people seldom communicate with precision, and even when they do they seldom agree. Add to this the similarly un-understood term "Health" and the opportunities for confusion multiply astronomically.

Perhaps things are not quite as bleak as all this. For instance most educators do know that there are three major areas of activity in school health: Health Services, Healthful Environment, and Health Education.

The first involves arrangements for such health services as periodic physical exams, immunizations, tuberculosis screening programs; and emergency care for the child who becomes ill or injured at school.

The second is concerned with providing a school environment which minimizes hazards and enhances the learning process. This includes a healthful emotional climate within the school, non-skid floors, accessible exits, proper heating and lighting, cafeteria sanitation.

These two areas, health services and healthful school environment are easy to visualize and comfortable for the educator to live with because they most often involve tangible, measureable objects and procedures, and are usually the primary responsibility of someone other than the classroom teacher.

The third area — health education — is very different because it **must** be an integral part of the instruction program. It is by nature intensely personal and practical to the student and is designed to help him learn how to live in a manner that will enhance health and discourage disease. The primary goal of health education is to prevent illness, not cure it.

TO FULLY APPRECIATE the importance of health education and its role in the prevention of illness it is necessary to be aware of the nature of the major threats to life and health in this country and how they have changed since the beginning of this century.

Very briefly the change has been from communicable diseases initiated by specific pathogens to chronic and degenerative disorders and accidents — conditions which often have no single cause but do stem from patterns of living adhered to over periods of many years.

It is, particularly, important to note that the methods used to bring the major communicable diseases under control have only limited application to most of our major health problems today. For example, even the most sophisticated sanitation and immunization measures or the most elaborate care and treatment facilities do relatively little to prevent **new** cases of cardiovascular disease, cancer, diabetes or mental illness.

Medical treatment in response to symptoms cannot always limit the incidence of most "modern" diseases. We cannot feel arteries hardening or fatty deposits building up in them, and it is a truism that the emotionally ill person is the last to admit that he needs help. When we respond to symptoms it is often too late to prevent serious illness.

FUTURE ADVANCES IN improving the health of the public will necessitate individual, voluntary, positive health behavior that leads to prevention of disease or its detection at a stage in which it can be most readily reversed or arrested.

Health education does have a vitally important role to play in early detection of disease but the fact remains that the only hope for primary prevention of many of our health problems is to help

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This article was first presented by Doctor Carlyon as an address before the 1968 Northern Michigan Health Conference at Houghton.

young people establish early in life patterns of behavior which we know will enhance health and discourage disease. This is what school health education is all about.

WHAT ARE SOME of these behavior patterns? Here are a few that help to determine the state of a person's health at any given time.

1. How he has handled his feelings under stress since childhood.
2. What value he has placed upon himself as a person since childhood.
3. What level of physical activity he has maintained since childhood.
4. What kind of a diet and how much food he has eaten since childhood.
5. What level of immunity to pathogens he has maintained since childhood.
6. How wisely he has utilized available health products and services . . . since childhood.
7. How well he has avoided accidents since childhood.
8. How many cigarettes he has inhaled since childhood.

Behavior patterns such as these which make up individual life styles, begin forming very early, long before a child goes to school. They are motivated by information and feelings and are learned from others.

Although no amount or kind of "healthful living" can guarantee an illness-free life, we do know enough about physical and mental health and about human development to know that such behavior patterns individually and, most often, in combinations have much to do with whether an elementary school child will become:

1. A drug dependent hippie at 20.
2. A welfare dependent divorcee at 25.
3. A mental patient at 30.
4. A heart attack victim at 40.
5. Or will die of lung cancer at 50.

The purpose of health education is to help children establish early in life patterns of living which we know will discourage just such tragedies and in the process allow them to fulfill themselves to the maximum of their capacities.

IN THE FACE OF all this that we know, it is inconceivable that we should continue to place such a low value upon health education in our schools as we have in the past. Learning how to live a healthful and satisfying life is every bit as important as learning how to add, or being able to recite the parts of speech, or knowing the major exports from Brazil.

It is not that the rest of the curriculum is unimportant. Everything a student learns at school can contribute to his overall well being. But, nothing is **more** important than learning how to live a healthful life.

There is a lot of activity labeled health education going on in schools and colleges across the country. Some of it is excellent. But a great deal of what is so labeled isn't health education at all. It is illness education — because it is being used as an antidote for health problems that have already developed, and such problems often turn out to be the dramatic ones which scare the daylights out of the adult community — sexual misconduct, unwed pregnancy, venereal disease, drug dabbling, and reckless driving.

CERTAINLY WE ARE IN favor of doing whatever we can to cope with such problems; but it is just as important to help young children learn to deal constructively with their impulses to aggression and gratification, as it is to bring a narcotics agent into the classroom in an effort to frighten teenagers out of using drugs. It is just as important to help children gain a knowledgeable awareness of their evolving sexuality as it is to have a crash sex education program in junior high in response to a pregnancy epidemic.

The story of health education in our schools has often been one of too little and too late. Unfortunately it is getting later and later and we still aren't doing enough about it.

TOO LITTLE, TOO LATE has also been a pattern in American life, particularly, regarding

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our health and social problems. Somehow we find it easy to accept the old myth that we can solve any problem that develops through application of good old American ingenuity and know-how. Science and medicine have done much to alleviate suffering and to prolong life and there will continue to be exciting breakthroughs in the health field. But much of what has been discovered in recent years supports the thesis that many of our major health problems are due to lives poorly lived and that you cannot change a lifetime of destructive health behavior with a magic pill or gadget. We cannot afford to wait until we can get a "safe" cigarette from the tobacco companies or a guaranteed heart transplant in our local communities. It is tragic if we pass blind faith in science and technology on to our children.

All of our future health problems exist, potentially, in our present school populations. The nature of these problems will be determined in large part by how these students live their lives during the next 20-30 years. If we really want to do something about these future health problems the time to start is now, and the place to begin is our schools.

We need comprehensive, balanced health programs in every school, including adequate health services, healthful school environment, and planned health education experiences from kindergarten through college. It would seem logical to place a special emphasis on the elementary schools where we can reach children at a time when their attitudes and life styles are still in formation.

NONE OF WHAT HAS been said here is intended to pose health education as a panacea. It isn't. But health education can be a major force in helping young people learn how to live constructively and healthfully with the demands of an environment which often appears to stretch the limits of human adaptibility.

The evidence in support of sound school health education is overwhelming.

It is time for action.

Hypercatabolic and Non-Oligurie Renal Insufficiency

BY J. C. ROSENBERG, M.D.
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(Editor's Note: Following is an abstract of a paper on "A Study of Hypercatabolic Non-Oliguric Renal Failure in Man," given by Jerry C. Rosenberg, M.D., at a meeting of the Detroit Surgical Association. Doctor Rosenberg is associated in the Department of Surgery at Wayne State University Medical School.)

Postoperative and post-traumatic patients with renal insufficiency have twice the mortality of medical patients with anuria. In an attempt to understand the reasons for this disparity in prognosis, we have studied, in detail, 6 patients with renal failure; in each instance this complication followed a major operation or massive trauma and fell into the category of either hypercatabolic (daily increase in blood urea greater than 60 mg/100 ml) or non-oliguric (elevation of blood urea and creatinine despite normal daily urine volumes) renal insufficiency. Hypercatabolic oliguric renal failure and non-oliguric renal failure result from a reduction in renal blood flow.

The severity of the tubular damage and the extent of the associated catabolic state determines which of the aforementioned syndromes will be produced. Infection and/or the presence of necrotic tissue was responsible for the hypercatabolic state in all of the patients. Previous renal disease was present in 2 of the 6 patients. From a therapeutic point of view, it is essential to differentiate the varieties of renal insufficiency. Failure to recognize these syndromes, and therapy which was too conservative, was responsible for the high mortality of 33%.

Adequate treatment requires the early onset of continuous peritoneal dialysis or the insertion of an external Scribner shunt and daily hemodialysis. Simultaneously, necrotic or infected tissue must be excised or physiologically eliminated by hypothermia.

Wine in Medicine

BY ARMANDO R. FAVAZZA, M.D.
ANN ARBOR
AUTHOR

Undoubtedly there is something basically majestic in wine, like blood or bread or lentils. Priests have consecrated it, poets sung paeons to it, philosophers praised it, physicians prescribed it. Perhaps it is merely coincidence, but the countries which have given art and "joi de vivre" to the world also include wine as a staple of life.

There are more than enough historical admonitions exhorting the use of wine as a medicine. In the Hebraic Talmud, wine is called "the foremost of all medicines." The physician Maimonides wrote about wine, "It contains much good and light nourishment. It is rapidly digested and helps to digest other foods. It also removes the superfluities from the pores of the flesh and excretes urine and perspiration."

The Book of Proverbs states, "Give strong drink unto him that is ready to perish, and wine unto those of heavy hearts." And St. Paul advised Timothy to, "Drink no longer water, but use a little wine for thy stomach's sake and thine often infirmities."

Hippocrates wrote, "No wounds should be moistened with anything except wine unless the wound is in a joint." Galen used wine to bathe the intestines of wounded gladiators before stuffing them back into the abdomen in order to prevent infection.

During the Renaissance wine was used as a rinse to decrease dental caries, and also as a stimulant for the liver and pancreas.

Pasteur declared that wine was ". . . the most healthful, the most hygienic of beverages." Wine was added to water and prescribed in France and Austria to combat typhus and cholera.

Pharmacology

The pharmacological properties of wine are far more varied than those produced by alcohol alone. Table wines average about 13 percent alcohol and fortified wines (sherry, port) about 20 percent alcohol. The pH of wine is 3.2, approximately that of gastric secretions. Wine alcohol is more slowly absorbed from the gastrointestinal tract than straight alcohol or alcohol and water, thus a great quantity must be drunk to cause a high alcohol blood level. Being a natural tranquilizer it has few side effects and may be considered as a mild hypnotic-sedative.

Because of their tartrate content, white wines serve as mild diuretics. The high K/Na ratio is favorable for the cardio-vascular renal system.[1]

The anthrocyanins, which contribute to the color of wine, are antibiotic in low concentrations and are especially effective against shigella, salmonella and typhoid.[2]

Cyanidol, which occurs as 1-3000 parts per million in wine, may act to reduce hypercholesterolemia.[3]

Wine also contains amounts of the vitamin P group (bioflavenoids) in sufficient quantity to be effective in maintaining the integrity of capillary structure.[4] Almost all the B vitamins are present in great enough quantity so as to be considered as a supplemental source.

Due to enzymes found in wines it has been reported that in some malabsorption syndromes, white wine with meals may restore fat absorption to normal.[5] The ferrous iron in wine is, of course, easily absorbed.

An average glass of wine contains about 95 calories, dry wines having lower sugar content. Insulin is not required to metabolize the alcohol in wine, and wines have been prescribed as part of a diabetic diet.[6]

It has been recently reported that one-half a liter of wine will lower intraocular pressure significantly in patients with glaucoma.[7]

Contraindications

Wine should not be prescribed for patients with the following conditions:

1. Alcoholism — except under controlled conditions when wine may deliberately substitute for crasser and more potent alcoholic beverages.
2. Specific allergy to wine.

The author, Doctor Favazza is a resident in the Department of Psychiatry, University of Michigan Medical School; and president of the Physician's Wine Appreciation Society of Greater Detroit.

3. Esophagitis or gastritis.
4. Pancreatitis.
5. Genito-urinary tract infections.
6. Prostatitis or benign prostatic hypertrophy.

Indications

While we might try to fool ourselves about the important pharmacological effects of wine there are more potent and specific agents we can use. Wine is a fine and neglected auxiliary nostrum, especially in elderly patients.

A glass of wine with a meal will make a drunkard of no one and it may help to alleviate minor tensions and may "promote geniality, conviviality, companionship, interest in others, appreciation of the environment, and overall bodily comfort."[8]

In a loosely-controlled large California study the authors conclude: "Whatever the physiological or psychological mechanisms involved, it seems obvious that the inclusion of small amounts of wine in hospital diets resulted in a substantial relaxation of tensions, indicated by a substantially lower number of complaints per patient. The use of wine with meals not only improved the palatability of the food with which it was served, but appeared to make the coffee taste better, reduce the unpleasantness of hospital smells, make the room seem less noisy, increase the courtesy and efficiency of receptionists and carriers, and generally improve the rapport between the patients and the physicians, nurses and technicians."[9]

A glass of port at bedtime may combat mild insomnia. An afternoon glass of sherry is a genteel custom to open the appetite, combat boredom and lead to relaxation. Sherry has also been prescribed to combat premenstrual tension due to its mild diuretic and tranquillizing properties. Champagne is a favorite European remedy for post-partum "blues."

Wine given to a hospitalized patient may do wonders for the hospital's image as a place where one comes for living and not for dying. Although wine is a staple of life throughout the world, in America it stirs up middle-class images of gracious living. Osler called wine "the milk of old age."[10] As our methods and mentalities become more mechanized, a glass of wine may be a thoughtful gesture, a touch of civility, an inexpensive way of expressing care and kindness.

It is not necessary to prescribe high quality, high-priced wines. Michigan is one of the nation's largest wine producing states and its wines, when bought in bulk, are negligible in price. Bulk wines are cheaper than fruit and vegetable juices and may be good replacements on the hospital evening cart!

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Editorial Comment:

Whether one is a teetotaler or not, many physicians will certainly enjoy reading this brief description of the use of wine in medicine. One could draw the reader's attention especially to its value as a psychological boost to the patient as herein described. (John W. Moses, M.D.)

Four-Year MSU Medical School Supported in Annual Address by Harris

A proposal that citizens, concerned with the supply of doctors in Michigan, help complete a four-year medical school at Michigan State University was made by the president of the Michigan State Medical Society at the 1968 Annual Session.

President B. M. Harris, M.D., Ypsilanti, suggested the "formation of citizens committees in Michigan communities to help support the efforts to graduate future doctors at MSU."

Doctor Harris declared, "The State Medical Society should strongly urge the development of citizen groups to augment physician appeals to the state legislature to provide the support necessary to expand the two-year MSU medical school to the full four years."

The State Board of Education has recommended the expansion of the two-year MSU school to a MD degree granting institution, but the legislature, to date, has not voted the necessary funds for expansion.

Greater use of community leaders to help increase the number of doctors trained in Michigan was advocated by Doctor Harris. In part, he said, "Medicine would like to ask the help of intelligent and dedicated laymen to aid in increasing the quantity and quality of medical care we can offer our patients."

"The doctors of medicine," reviewed Doctor Harris, "have endorsed for several years the expansion of the two-year MSU school to become the third medical school in Michigan."

Every effort must be attempted to close the gap between public demand for medical services and the number of Michigan doctors of medicine, Doctor Harris said. "Our greatest prospect lies in funding by the legislature to expand the medical schools at the University of Michigan and Wayne State University and to obtain a four-year medical school at MSU."

Doctor Harris pointed to a recent Brookings Institute Report on the doctor shortage. The Institute predicts that the demands for medical services in the 1965-75 decade will increase between 22 and 26 per cent, while the supply of physicians will increase by less than 20 per cent.

B. M. HARRIS, M.D.

In his annual report, Doctor Harris said, "Although there is a strong basic science program at Michigan State and a new life sciences building, the present great need there is financial support. More state funds must be appropriated by the state legislature to develop the clinical areas of the medical school curriculum."

MSU began its two-year school in the fall of 1966.

Photo Highlights From Annual Session

OTHER PHOTOS APPEARED IN OCTOBER EXTRA; MORE NEXT MONTH

Information about the seriousness of health quackery was stressed in comments to the Michigan State Medical Assistants Society convention by Brock E. Brush, M.D., left, Detroit, Chairman of the MSMS Public Relations Committee, and James J. Lightbody, M.D., MSMS President.

Harry Dowling, M.D., right, of Chicago, who gave a speech about "Government, Medicine and Drugs" at one of the Annual Session Luncheons, visits with A. Martin Lerner, M.D., Detroit, a member of the Annual Session Program Committee.

James J. Lightbody, M.D., receives a Past Speakers Pin from Speaker James B. Blodgett, M.D., as one of the special ceremonies during the Annual Session. Doctor Lightbody had served as Speaker for eight years through the 1967 session, when he was chosen as President-Elect.

State Auxiliary officers were part of the receiving line for the Presidents Party during the Annual Session in the Sheraton-Cadillac Grand Ballroom. The couple at left is Dr. and Mrs. Earl Weston, Detroit, and the couple at the right is Dr. and Mrs. W. G. Gamble, Jr., of Bay City. Mrs. Weston is the new President of the Woman's Auxiliary to MSMS for 1968-69, and Mrs. Gamble is the outgoing President.

Table signs marked the locations of the county society delegations at the House of Delegates meeting of the Michigan State Medical Assistants Society annual meeting at the Pontchartrain Hotel.

Miss Helen A. Schulte, who serves as staff assistant for many of the MSMS scientific committees, was honored by the House of Delegates for 25 years of loyal, efficient service. Robert J. Mason, M.D., pointed out that Miss Schulte is the second MSMS employee to complete a quarter of a century of employment — the other was William J. Burns, who retired several years ago as the executive director.

Robert J. Roney, right, MSMS controller, receives warm congratulations of Robert J. Mason, M.D., when the House of Delegates honored Mr. Roney for 20 years of loyal, efficient service.

George L. Reno, M.D., Detroit, presided at the 1968 MDPAC Breakfast in Detroit during the Annual Session. Doctor Reno, Secretary of the Wayne County Medical Society, is a member of the MDPAC Board of Directors.

In photo below, James J. Lightbody, M.D., Detroit, gives his message as president-elect to the 1968 House of Delegates.

Every year during the MSMS Annual Session, the former leaders of the State Society get together for a social evening and the chance to discuss projects they helped carry out for MSMS. The 1968 dinner meeting was held at the Detroit Athletic Club.

Past MSMS Officers In the Camera Eye

AT LEFT — D. Bruce Wiley, M.D., right, formerly of Utica and now of Lansing, former Chairman and Secretary of The MSMS Council, exchanges comments with Gerald D. Dorman, M.D., New York City, President-Elect of the AMA.

Three former MSMS officers visit with Gerald D. Dorman, M.D., AMA President-Elect, at the Past Officers Dinner. Left to right are H. R. Carstens, M.D., Detroit, who was speaker in 1928-29; Doctor Dorman; L. W. Hull, M.D., Detroit, President in 1953-54; and Luther R. Leader, M.D., Royal Oak, President in 1965-66.

Three past presidents are caught in the middle of a good story — Left to right are Kenneth H. Johnson, M.D., Lansing, President, 1960-61; George W. Slagle, M.D., Battle Creek, President, 1957-58; and G. B. Saltonstall, M.D., Charlevoix, President, 1958-59. Doctor Johnson currently serves as the MSMS Secretary.

C. Allen Payne, M.D., left, Grand Rapids, President during 1966-67, tickles the funny bone of Hugh W. Brenneman, Executive Director.

In photo above at left, B. M. Harris, M.D., visits with two visiting dignitaries. Newton DuPuy, M.D., President of the Illinois State Medical Society, is center, and Robert Howard, M.D., Past President of the Ohio State Medical Society, is at right.

Orlen J. Johnson, M.D., right, Bay City, President of MSMS during 1963-64, talks about health planning with George W. Slagle, M.D., Battle Creek, President during 1957-58. Between the two in the background is Otto B. Beck, M.D., Birmingham, President during 1951-52.

BELOW — Otto K. Engelke, M.D., left, Ann Arbor, MSMS President in 1961-62, discusses current medical issues with Oscar D. Stryker, M.D., Mt. Clemens, former Speaker of the MSMS House of Delegates in 1940-41 and 1941-42.

MSMS Offers Advice on Transplants To State Legislative Committee

The Michigan State Medical Society has pledged its complete support to the new Michigan Legislative Committee on Transplants of Human Body Parts.

The medical society has informed the committee chairman, Senator N. Lorraine Beebe, that its members who are well informed in this field are available as resource persons, and that its extensive files of technical reports and scientific papers are at the disposal of the committee.

When the committee conferred in Lansing, October 9, C. Allen Payne, M.D., of Grand Rapids, a past president of the state medical society, was present as an invited resource expert.

Doctor Payne and Senator Beebe attended a conference in Washington, D.C., September 30 on "Medical-Legal Issues Relating to Tissue Transplantation." The meeting was sponsored by the National Research Council.

MSMS also helped arrange for Senator Basil Brown, who introduced the resolution creating the committee, to attend a special American Medical Association-sponsored program in June on "The Limits of Medical Responsibility in the Prolongation of Life."

The Michigan legislature on January 11 adopted a resolution to create the Special Committee on Transplants of Human Body Parts. The resolution, introduced by Senator Basil Brown, also outlined the broad functions of the committee in preparation of a report to the 1969 legislature.

The special committee has been appointed to include five senators and five representatives, with Senator N. Lorraine Beebe as chairman and Representative William L. Jowett as vice-chairman.

The legislative resolution praised the recent successes of surgical transplants of human body parts for bringing "new hope for all in the never ending battle against disease and accidents," and pointed out "that the same successes raise new legal and moral questions for which answers do not presently exist."

The resolution declared further, "it is in the public interest that these questions be answered to the end that such research can be continued."

The special joint-legislative committee has been charged, "to study all phases of the subjects of transplants of human body parts and to report its findings and recommendations to the 1969 legislature."

The membership of the Human Transplant Committee includes the following State Senators—N. Lorraine Beebe, Chairman, Harry A. DeMaso, James G. Fleming, Basil W. Brown and Roger E. Craig; and State Representatives William L. Jowett, Vice-Chairman; Peter Kok, Dale Kildee, Daniel S. Cooper and Thomas L. Brown.

Attorney General Frank Kelley (in a "Know Your Michigan Law" newspaper column) on February 19, 1968, declared in part:

"Fortunately the Michigan legislature has provided answers to many of these questions (about transplants) by passing Act 82, of the Public Acts of 1958, as amended. The legislation authorizes and regulates the donating of all or any part of the human anatomy for various purposes."

Attorney General Kelley in May called for action to give firmer legal foundation for heart transplant operations in Michigan.

He declared that "the major task of the law is to facilitate the supply of anatomical parts needed for medical education and transplant purposes."

Attorney General Kelley said, "If science can make the startling breakthroughs that it has in the transplant area, with the difficult problems it was required to surmount, certainly we can make the necessary efforts to make the law a more helpful tool in this life-saving process. We certainly have the obligation to try."

"New legislation providing more definite rules is necessary," Attorney General Kelley said, "if we are to facilitate transplants through donation by the deceased's survivors."

He reported that there is no Michigan legislation regulating consent of the deceased's survivors to removal operation for transplant purposes. He pointed out, "however, a criminal statute which makes it a felony to mutilate any portion of a dead body without lawful authorization does set some limits."

The Attorney General indicated that possible new legislation should be "passed after lawyers, doctors and other concerned and informed citizens have played a part in giving it content."

Attorney General Kelley suggested the law should protect the doctors involved in removal operations against legal liability, and the law should constantly strive to provide the maximum feasible amount of certainty regarding the legal rights of all concerned."

Attorney General Kelley said, "Michigan law, fortunately, affords licensed medical practitioners and medical and educational institutions protection against civil liability for removing organs given as provided in the act where the gift has not been revoked."

Available as a guide for the Michigan legislative committee and the Michigan legislature as it considers possible new laws is the new "Uniform Anatomical Gift Act." This act was developed by the National Conference of Commissioners on Uniform State Laws and then endorsed by the American Bar Association.

The National Conference of Commissioners on July 30 gave approval to the uniform act, which it reports was "designed to facilitate donations and use of organs and other tissues for transplantation and other medical purposes."

The American Bar Association House of Delegates in August approved the uniform act and urged adoption by the state legislatures.

The proposed act will be distributed to all state legislatures as a nationwide model.

The matter of transplants also is under discussion in Congress. Senator Walter F. Mondale in 1967 proposed a Commission on Health, Science and Society to study transplants and many other matters which he called "profound and complex questions of law, ethics, and public policy."

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11 Michigan Physicians Honored For Volunteer Service in Vietnam

Eleven Michigan doctors of medicine who have served as volunteers in Vietnam this past year were honored at the 1968 Michigan State Medical Society meeting in Detroit.

Plaques for meritorious service were presented the doctors by Gerald D. Dorman, M.D., New York City, president-elect of the AMA.

The Michigan physicians, who each served two-month stretches for a total of 22 months, are:

Daniel D. Chapman, M.D., Owosso;
J. Colin Elliott, M.D., Buchanan;
Joseph A. Grady, M.D., Detroit;
Seymour Krevsky, M.D., Detroit
Armand M. LaSorsa, M.D., Manistique;
Donald Lipsey, M.D., Durand
Adrian J. Neerken, M.D., Kalamazoo;
Leonard M. Pickering, M.D., Southgate;
Henry C. Scharnweber, M.D., Midland;
Roger A. Scholten, M.D., Kalamazoo; and
Daniel B. White, M.D., Birmingham

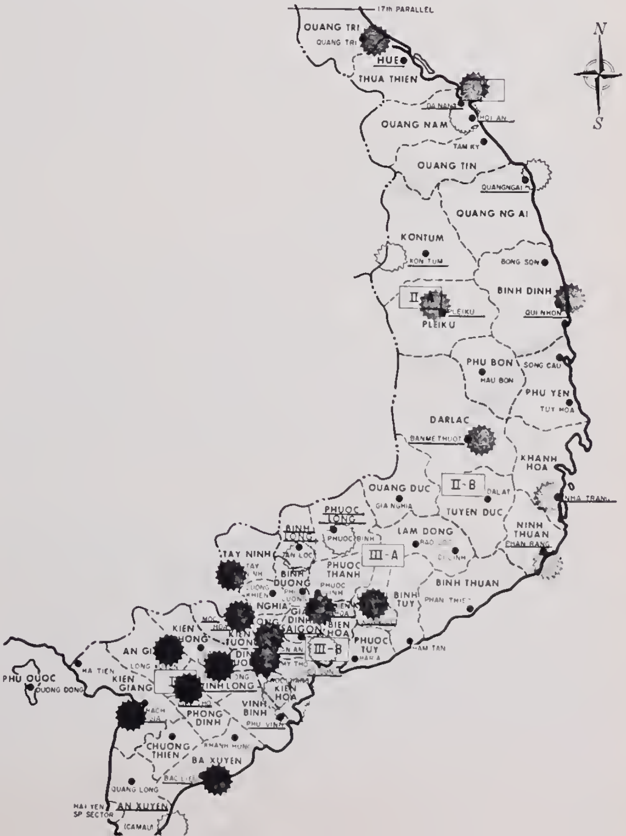
The awards were "Certificates for Humanitarian Service," and recognized the doctors of medicine "for treating the ill and injured during his medical mission."

The physicians and their wives were guests of MSMS for dinner before the House of Delegates session. Hira Branch, M.D., Flint, chairman of the MSMS International Medicine Committee, was the host.

Three Michigan physicians were honored a year ago. Since then the medical society has conducted a more active educational effort to get more Michigan doctors to volunteer for two months.

The AMA Physician Volunteers for Vietnam Program began three years ago and has sent more than 500 doctors to help the civilians in South Vietnam.

The map of South Vietnam shows the locations of physicians serving on AMA Volunteers Project. The current locations are marked with grey seal-shapes and former locations are in outline seal-shapes.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ACTIVITIES, PROJECTS

U-M Creativity Symposium Open To All Dec. 1

Michigan physicians are invited to participate in the "Symposium on Creativity, Conformity and Concepts of the 20th Century Adolescent," December 1 at the Sheraton Motor Inn in Ann Arbor.

A banquet, at 6:00 p.m., will feature an address, "Changes in Society's Procedures for Handling Juvenile Delinquency," by the Honorable Orman W. Ketcham, Judge, Juvenile Court of the District of Columbia.

All persons attending the symposium are invited to this banquet. Requests for banquet tickets should be forwarded together with personal checks ($5.00) made payable to "Symposium on Adolescents" and mailed to Department of Postgraduate Medicine, W5610 University Hospital, Ann Arbor, Michigan 48104.

The symposium is open to all physicians, their wives, and professionally allied colleagues. Members of the law profession who are closely concerned with medicolegal problems are also cordially invited. No registration or other fees are required for the lectures; however, because of seating space limitations, only those holding complimentary admission tickets can be accommodated. Further information and ticket applications will be sent to Michigan physicians or may be obtained by addressing requests to: Harry A. Towsley, M.D., Chairman, Department of Postgraduate Medicine, University of Michigan Medical Center, W5610 University Hospital, Ann Arbor, Michigan 48104.

The conference will be sponsored by the U-M Departments of Psychiatry and Postgraduate Medicine, the Michigan Society of Neurology and Psychiatry, and MSMS.

The symposium will explore the more recent trends in the general attitudes of youth, their sex mores, value systems, and psychological approaches to the search for identity. The entire program is designed for the benefit of the practicing physician who is now increasingly expected to deal firsthand with these problems.

The symposium has been made possible by an educational grant-in-aid from and with the assistance of Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York.

The first speaker at 1:15 will be Raymond W. Waggoner, M.D., U-M, on "The Adolescent Patient," followed by E. J. Hornick, M.D., Albert Einstein College of Medicine, on "Parentage and Parenthood Versus Creative Adolescent Turmoil."

Other afternoon speakers will include Fritz Reidl, Ph.D., WSU, on "Rebellious Youth and the Futility Syndrome;" Daniel Offer, M.D., Michael Reese Hospital, on "Sexual Problems Faced by Today's Normal Adolescent Girls;" and Dave L. Farnsworth, M.D., Harvard University, on "Adolescents' Abuse of Illicit Drugs; Facts Versus Fallacies."

MARMP GETS $1,652,273 GRANT

Albert E. Heustis, M.D., executive of the Michigan Association of Regional Medical Programs, has announced that MARMP organization has been awarded a $1,652,273 grant by the U.S. Public Health Service for educational programs and other studies to combat heart disease, cancer, stroke and related diseases.

Part of the grant will support the central coordinating staff in Heustis' office. The grant will also be used to finance projects designed to improve care of patients who have the diseases and to support planning staffs at three state universities and the State Public Health Department.

SEEK BIOMED PAPERS FOR U-M PROGRAMS

Interested physicians are invited to submit papers for the 7th National Biomedical Sciences Instrumentation Symposium, May 19-21 at the University of Michigan. Abstracts must be received no later than December 15 by Ernest E. Sellers, Host Chairman, Box 618, Ann Arbor 48107.

The conference, "Imagery in Medicine," will be sponsored by the University of Michigan and the ISA.

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine*; and watch for the *News Extra* during the middle of each month.

Walt Appointed Associate Dean; Other Changes

Several administrative appointments have been announced by Ernest Gardner, M.D., Dean of The Wayne State University Medical School.

Alexander J. Walt, M.D., since 1964 Assistant Dean at the medical school, has been appointed Associate Dean. He holds The Grover C. Penberthy Chair in Surgery.

Lawrence Power, M.D., who joined the medical faculty in 1965 as associate professor of internal medicine, has been named Assistant Dean. In his new position, Doctor Power will be responsible for the clinical implementation of the school's new curriculum. He will also represent Wayne State University as co-director of the Institute of Gerontology, serving with a representative of the University of Michigan.

Windsor S. Davies, M.D., clinical professor of ophthalmology and a member of the faculty since 1949, has been appointed Acting Chairman of the Department of Ophthalmology, filling the vacancy created by the retirement of Albert D. Ruedemann, M.D.

Ralph G. Smith, M.D., professor of occupational and environmental health and member of the faculty since 1955, has been appointed Acting Chairman of his department. Arthur J. Vorwald, M.D., chairman since 1954, has taken a long-term medical leave.

Ben Rubenstein, Ph.D., Director of Admissions and Student Advisement, is on sabbatical until July 1, 1969 to conduct research on admission policies and practices. Harry Maisel, M.D., professor of anatomy, has been named Acting Director.

MRS. GAMBLE NAMED TO REGIONAL POST

Mrs. W. G. Gamble, Jr., immediate past president of the Woman's Auxiliary to MSMS, has been appointed North Central Regional Safety and Disaster Preparedness Chairman for the National Auxiliary.

Mrs. Gamble, who will serve 12 states, participated in the North Central Regional Workshops, October 14-15 in St. Louis.

The annual fall conference of the national Woman's Auxiliary in Chicago in September was attended by Mrs. Earl Weston, current Michigan president; Mrs. Edward S. Maxim, president-elect, and Mrs. Gamble.

MEDISCENE

Nov. 6 — The Council, MSMS Headquarters, East Lansing

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

Nov. 13 — Michigan Diabetes Association Symposium on Diabetes, Sinai Hospital, Detroit

Dec. 1-4 — AMA Clinical Convention, Miami Beach

Dec. 12-13-14 — 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing

Dec. 18 — The Council, MSMS Headquarters, East Lansing

Jan. 29 — The Council, MSMS Headquarters, East Lansing

Jan. 30 — State Woman's Auxiliary to MSMS, Board of Directors, MSMS Headquarters, East Lansing

Feb. 3-10 — Childrens Dental Health Week

March 12 — The Council, MSMS Headquarters, East Lansing

March 25-26 — Eighth Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

May 21 — Annual Muscle Symposium, Wayne County Medical Auditorium, Detroit

TB SOCIETY PLANS CHRISTMAS SEAL SALE

Plans are being advanced by the Michigan Tuberculosis and Respiratory Disease Association for the 1968 Christmas Seal sale.

Association officers point out that most people associate Christmas Seals with the fight against tuberculosis, but many are unaware of the Christmas Seals' role in fighting other respiratory diseases such as emphysema, chronic bronchitis and asthma. In Michigan, emphysema deaths alone have risen from 228 in 1957 to 1045 in 1967.

In tuberculosis control much effort is placed in research, detection and education. Contributions also support the implementing of breathing exercise courses for asthmatic children and persons suffering from respiratory ailments, smoking education in our schools and smoking withdrawal clinics, and tuberculin skin testing and chest X-ray programs.

PROMOTED BY DOW

Charles W. Hinman, Ph.D., has been named by Dow Chemical Company to the newly-created position of assistant director of research for the life sciences. He has been with Dow since he received his doctorate in organic biochemistry from the University of Illinois in 1954.

26 Doctors Get MSMS Pins for 50 Years Service

Every year Michigan doctors who have completed 25 years of service receive a coveted pin before the House of Delegates.

This year, 26 Michigan physicians were eligible for the "50-year Service Pins." Nine were present to receive the Michigan award in person before the delegates. The other pins will be mailed.

The honorees included one past president — Edward F. Sladek, M.D., of Traverse City, and two former MSMS Council members — W. C. C. Cole, Sr., M.D., formerly of Detroit, and John T. P. Wickliffe, M.D., formerly of Calumet, both in California now.

The complete list of 50-year men are: Edward F. Sladek, M.D., Traverse City; Lloyd C. Harvie, M.D., Saginaw; M. S. Hurth, M.D., Ingham; W. B. Lewis, M.D., Battle Creek; Garnet G. Stonehouse, M.D., Grand Rapids; William V. VanderVoort, M.D., Hastings; Karm C. Kerwell, M.D., Stephenson; Alton R. Marsh, M.D., Dearborn; Sol M. Lewis, M.D., Ferndale; Joseph A. Kasper, M.D., Grosse Pointe Park; Elden C. Baumgarten, M.D., Grosse Pointe Woods; and Fred O. Lepley, M.D., Grosse Pointe Woods; Alfred H. Whittaker, M.D., Grosse Pointe; from Detroit — Clyde K. Hasley, M.D.; Arthur B. Norton, M.D.; Robert L. Novy, M.D.; Harold F. Raynor, M.D.; John B. Rieger, M.D.; Isaac S. Schembeck, M.D.; James M. Stanton, M.D.; Milton D. Vokes, M.D.; Ray S. Dixon, M.D.; William E. Hilton, M.D.; and also John T. P. Wickliffe, M.D., formerly of Calumet and now of Escondido, California; A. M. Giddings, M.D., formerly of Calhoun County, now of St. Mary's, Ohio; Wyman C. C. Cole, M.D., formerly of Detroit, now of Walnut Creek, California.

AMA Offers Folders About Drug Abuses

Because of the rising incidence of drug abuse in the United States, especially among young people, the American Medical Association has published five related pamphlets, "Amphetamines," "Barbiturates," "Marijuana," "LSD," and "Glue Sniffing."

Written originally for the 1968 Community Health Week program on drug abuse, the one-page pamphlets answer many of the questions frequently asked about this growing problem. In addition to describing the effects of these dangerous substances on the body, each pamphlet stresses the hazards of experimentation, the psychological effects on the users and the legal controls.

Review copies are available from the AMA's Department of Health Education. Quantity copies are available from Order Handling at 15 cents each; 50-99 copies, 14 cents each; 100-499 copies, 12 cents each; 500-999 copies, 10 cents each and 1,000 or more copies, 8 cents each.

CURRICULUM CHANGED

WSU Freshmen Get Introduction To Patient Care

A redesigned medical curriculum at Wayne State University went into effect on September 30. Ernest Gardner, M.D., dean of the School of Medicine, reports the 1968 entering freshmen, number 130, will be the first under the new program.

To the freshmen, the new curriculum means getting an introduction to problems involving patient care during the first year, rather than in the third year. They will study social and behavioral sciences, stressing the changing social and community roles of today's physicians. An integrated basic science curriculum in human biology will be taught by the departments of anatomy, biochemistry and physiology.

Dean Gardner said, "The new undergraduate program places emphasis on relating basic science knowledge to patient care. Flexibility through expanded electives will enable preparation for a variety of careers within the general divisions of private practice, academic medicine and research."

During their second year at the medical school, this year's freshmen will study physiology, pharmacology, pathology, microbiology, biostatistics, epidemiology, special topics in biochemistry and psychiatry, plus an intensive course in obtaining medical histories and performing physical examinations. Appreciation of medical history, culture and heritage will also be stressed.

Revision of the third year curriculum calls for clinical core courses in internal medicine and related specialties, surgery and related specialties, gynecology and obstetrics, pediatrics, psychiatry, and family and community medicine. Elective studies will make up the senior schedule.

Students who are now sophomores at the medical school will study phased-in portions of the new curriculum. Upper classmen will continue with much of the former program, laced with more relaxed policies on electives.

New House-Introduced Laws Bearing on Medicine Described

BY HERBERT MEHLER
OF THE MSMS STAFF

Community Mental Health Services Law

Public Act 265 (House Bill 2294) amends Act 54, the Community Mental Health Services Act, so that the legality of a city-county board in Wayne County is no longer in question, and writes a new definition of eligible mental health programs more in keeping with the concept of comprehensive services. It provides that community clinics must come under the local mental health board by contract or direct administration within four years and gives the Director of the Department of Mental Health authority to extend this period for a reasonable time.

Amended is the Department's rule-making authority so that program priorities and minimum numbers and scope of services and activities of community mental health board programs may be prescribed by rule. Standards for professional personnel will be established by the State Department of Mental Health.

Repeal of the Criminal Sexual Psychopathic Act

Public Act 143 (House Bill 3387) repeals the 1939 law generally referred to as the "Goodrich Act." The legal category of criminal sexual psychopath is abolished. The remaining tools in our law for dealing with sexual offenders are as follows: the offender, if convicted of a crime, may be sentenced to prison; a provision of the Criminal Code adopted in 1952 provides that a sexual offender, if determined to be "sexually delinquent" as defined, may be sentenced to prison on a day-to-life basis or an indeterminate sentence, a statute which has been little used in the past; and under the Civil Commitment Act, a sex offender may be committed by the probate court if there is no criminal charge pending.

Clarification of Hospital Act

Public Act 125 (House Bill 3808) amends Section 9 of the Hospital Act for Mentally Diseased Persons to make clear that a peace officer, with the approval of the prosecuting attorney, may confine a mentally sick person in a hospital, home or other place of detention, not just a jail. Certification by two legally qualified physicians is required with temporary detention not exceeding five days unless the probate court shall be a special order enlarging the time. Persons manifesting homicidal or other dangerous tendencies can be confined in a jail or other lock-up facilities.

Also amended was Section 10 of the Hospital Act relating to qualifications of certifying physicians by eliminating the requirement that such physicians "must be permanent residents of the State."

Clarify Use of Sheltered Workshop Fees

Public Act 89 (House Bill 3643) allows a department hospital to retain fees collected in sheltered workshops operated by the hospital, and to use such funds to purchase supplies and equipment and to pay patients.

Licensing and Supervision of Clinical Laboratories

Public Act 235 (House Bill 2378) defines a clinical laboratory as a "facility which may be patronized by any physician, health officer or other person authorized by law for the purpose of ob-

(Editor's Note: The September issue of **Michigan Medicine** described Senate bills which passed the 1968 Legislature and were given immediate effect. The following article briefly discusses House-introduced new laws which became effective upon being signed by the Governor. Subsequent articles will cover laws that become effective 90 days after adjournment of the Legislature on August 16, 1968. Copies of these laws are available by writing MSMS, 120 W. Saginaw, East Lansing 48823.)

taining information for the diagnosis, prevention or treatment of disease or the assessment of medical condition by examination of materials derived from the human body." This Act does not apply to laboratories operated by a person licensed or registered to practice medicine, who performs laboratory tests or procedures, personally or through his employees, solely as an adjunct to the treatment of his patients; of any college, university or school approved by the Department of Education which is conducted for the training of its students, if the results of any examination performed are not used in the diagnosis and treatment of disease; or those operated by the Federal Government.

The Director shall appoint a State Laboratory Facilities Council to assist with development of rules composed of three pathologists, one physician who is not a pathologist and is not directly associated with a clinical laboratory, two laboratory directors who are not physicians, one clinical chemist and one micro-biologist. The Director, with concurence of the council, shall promulgate, amend and rescind rules with reference to clinical laboratories.

Treatment and Rehabilitation of Alcoholics

Public Act 22 (House Bill 2961) defines alcoholism as a "chronic and progressive illness, characterized by an excessive and uncontrolled drinking of alcoholic beverages, and as a public health problem affecting the general welfare and economy of the state." The Act authorizes educational preventive programs for the treatment and rehabilitation of alcoholics; defines the duties of the Department of Public Health and establishes and defines powers and duties of a state advisory board of alcoholism.

The Act acknowledges the administrative transfer of the formally separate Board of Alcoholism through the principle Department of Public Health, as well as expanding the Advisory Council consisting of three licensed physicians one of whom shall be a qualified psychiatrist. The other four members represent the general public.

Sale and Possession of Certain Drugs

Public Act 126 (House Bill 3270) prescribes penalties for selling, offering for sale, bartering or otherwise disposing of or in possession of certain drugs, such as LSD, peyote, mescaline and its salts, DMT, silocyn, or psilocybin or any salt or derivative of the aforementioned or any drug possessing similar hallucinogenic properties.

Boards of County Institutions

Public Act 149 (House Bill 3467) permits counties with a population of less than 1,000,000 having an approved county tuberculosis hospital, the Board of Supervisors may create and appoint a board of county institutions for the purpose of maintaining and operating a county tuberculosis hospital, a county medical care facility and a county psychiatric facility; or may operate and administer all three as a single medical institution. Provisions also include authority to employ an executive head and other personnel and grants authority to the board for establishing policies covering operations of the hospital or institution, including the conditions of admission and the rates to be charged.

Regulates Narcotic Drugs

Public Act 86 (House Bill 3601) regulates and safeguards legitimate use of and traffic of narcotic drugs and exempt narcotic drugs; suppresses the illegitimate use, possession, control, sale, manufacture, production, disposition, administering, compounding, dispensing, prescribing and traffic by providing penalties for violations.

Public Act 103 (House Bill 3602) states: No prescription for any habit forming drug issued before or after the effective date of this Act may be filled or refilled more than six months after the date on which the prescription was issued and no such prescription which was authorized to be refilled may be refilled more than five times, except that any prescription for such a drug after six months after the date of issue or after being refilled five times may be renewed by the practitioner issuing it either in writing or orally if promptly reduced to writing and filed by the pharmacist filling it.

Appointment or Election of Medical Personnel to State Positions

Public Act 255 (House Bill 3776) provides that either a licensed medical physician or a licensed osteopathic physician is entitled to equal consideration, except on licensing boards, to appointment to governmental positions or service on state, county, city, township or other public agencies, departments or subsidiaries, wherever the laws of the state require such service.

Physician Must Help Detect Diabetes

BY HENRY D. KAINE, M.D., CHAIRMAN
DIABETES DETECTION COMMITTEE
MICHIGAN DIABETES ASSOCIATION

Diabetes Detection Week will be observed in Michigan and throughout the country November 17-23. The purpose of this intensified version of the year-round program to find the unknown diabetics and to test them, is to focus attention, with the help of the communications media, on diabetes and the need for early detection of diabetes.

In Michigan we are undertaking a program of free post-prandial blood sugar tests during Detection Week. Michigan hospitals have been asked to participate in this program. We are also asking the cooperation of the physicians of Michigan in this program. Helping to detect diabetes is one way of giving better medical care to more people. On the average, out of 122 patients who come into a physician's office, one will be an unknown diabetic. The earlier his diabetes is diagnosed and treated, the more successfully it will be controlled. MSMS members seeking additional information may write me at Michigan Diabetes Association, 6131 West Outer Drive, Detroit, 48235.

The importance of Detection Week was expressed by an editorial in the Journal of the American Medical Association for November 8, 1965: ". . . much work remains to be done. The drive stands in need of extension into areas where it has not yet penetrated. Toward that end Diabetes Week . . . needs the active participation of many more physicians. It would be a real service to patients, to the profession, and to the public if this year during Diabetes Week every physician in private practice would test for diabetes each of the patients he sees."

The Diabetes Detection Committee of the Michigan Diabetes Association urges physicians to do post-prandial blood sugar tests on their patients during Detection Week as a public service.

The Diabetes Detection Drive can succeed only with the cooperation of the practicing physician. He represents the first and main line of detection, as he is ultimately responsible for treatment. His help is essential if unknown diabetics are to be brought under medical care and thus remain effective members of the community.

Views Invited Re Drug Reports

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

A Drug Information Center has been established at the University of Michigan under a grant from the Michigan Association for Regional Medical Programs, Inc. to act as a rapid, random access service function to the medical professions of the state of Michigan. Its goal is to help bridge the gap between the medical professions and the estimated 200,000 articles of medical interest published per year as a meaningful and useful service.

The center is open 24 hours a day and may be reached by dialing 313 763-0243 or by writing the Drug Information Center, University Hospital E 3103, 1405 E. Ann Street, Ann Arbor, Michigan 48104.

The Drug Information Center received 30 requests in January and has progressed to 129 requests in July with a high of 146 requests in June.

Types of questions asked in July were: 1) Dosage - 26, 2) Therapeutic use - 13, 3) Side effects and/or contraindications - 1, 4) Availability - 26, 5) Adverse reactions - 4, 6) Therapeutic compatibility - 2, 7) Pharmaceutical compatibility - 10, 8) Identification - 27, 9) Toxicity - 3, 10) Metabolism - 1, and 11) other (stability, solubility, cost, etc.) - 16.

From these requests a good picture of some of the drug problems facing physicians should be available.

Your editors would like to establish a regular feature based on the information sought from the Drug Information Center. Such format might include lists of drugs and questions, "Drug Information Question of the Month" with in-depth discussion and answers or combinations.

Your editors would like to hear from readers as to their desires.

Be A Doer

Theodore Roosevelt, 26th president of the U.S. (1901-1909), emphasized the need for persons to try to improve politics rather than merely find fault:

"It is not the man who sits by his fireplace reading his evening paper and saying how bad our politics and politicians are who will ever do anything to save us; it is the man who goes out into the rough, hurly-burly of the caucus, the primary, the political meeting, and there faces his fellows on equal terms.

"The real service is not rendered by the critic who stands aloof from the contest, but by the man who enters it and bears his part as a man should."

What Are The Reasons?

FROM THE NEBRASKA
MEDICAL SOCIETY JOURNAL

Some 14,000 students became finalists in the National Merit Scholarship program, and 10,770 of them chose their careers.

Seven percent of them, or 767, want to be doctors.

Only 767 out of 14 thousand?

Last year, eight percent, or 950, chose medicine.

The decline may seem like only one percent, *but it isn't.* When you go from *eight* of anything to *seven,* you've dropped one part in eight, and that's twelve and a half percent.

From 950 to 767 is a big drop. To bring home this point more forcibly, a fall from 950 to 767 is a decrease of 19.2%. To make it even stronger, the year-ago number was 23.9% larger than this year's.

We seem to be declining in quantity and, if we may say so, in quality.

It is easy, much too easy, to conclude that things are just fine, that the top students are still entering medicine.

But they're not. Just look at the figures.

Last year's total was higher than the one for 1965-1966. And guess what happened in 1966. Oil companies discharged geologists after the Suez crisis, and geology enrollment fell sharply. And if after 1966, fewer top students want to be doctors, our politicians should be told, and they should be told why.

More schools may give us more students, and we are not at all sure of this, but they won't give us better ones. The better ones aren't interested, not like they used to be.

We can only hope that the government will look at these figures and think, and call a halt to the socializing of medicine, and make the practime of medicine inviting.

The way it used to be.

Let's Take The Lead

FROM NEVADA STATE
MEDICAL SOCIETY JOURNAL

In no area of human activity is the folly of trying to reach a desirable goal by merely writing laws and spending tax funds more apparent than in the field of health care. Acting Health, Education and Welfare Secretary Wilbur Cohen, an outspoken welfare advocate, recognized this when he questioned the feasibility of expanding Medicare at this time. Although a staunch supporter of more government in medicine, he said such action would be "to precipitate." He told news reporters that shortage of hospital beds and physicians are problems that need solving first.

The medical profession is taking the lead in helping to solve these problems. Through its spokesman, the American Medical Association, the profession has called for all medical schools to "accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted." It also supports federal participation in medical school construction to encourage applicants to be admitted. It also supports federal participation in medical school construction to encourage a greater production of physicians.

The president of the American Medical Association expressed the attitude of his colleagues when he commented, "Medicine has not failed the nation. Granting the existence of problems, we have today a firm base of widespread excellence upon which to construct the additional improvements which all of us recognize are needed."

The quickest way to destroy high medical standards would be to treat doctors as if they were public property, and to swamp their good works in an orgy of government medicine.

Going to Miami?

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

The American Medical Association conducts two national meetings a year, the Annual convention and the Clinical convention. The 22nd Clinical Convention will be held in Miami, Florida, December 1-4, 1968. The Clinical Convention is beamed to the busy practitioner and attempts to inform the physician of the latest advances in medical knowledge and technology.

During this year's Clinical Convention there will be 125 exhibits reflecting the latest developments in pharmaceuticals, medical equipment, and scientific endeavors. There will also be special postgraduate courses in diabetes, fluid and electrolyte balance and thyroid disease. About thirty medical motion pictures and live color scientific television programs will be offered. Clinical workshops and four breakfast roundtables will complete the program.

In these days when scientific progress is advancing so rapidly, the 22nd Clinical Convention offers a rapid and enjoyable way of keeping abreast of the latest developments.

Give your wife a day in the sun while you increase your knowledge.

See you in Miami.

MASON, HUFF CHOSEN AS CO-CHAIRMEN

Michigan Leaders Endorse MSMS Proposed Citizens Committee on Medical Manpower

A Michigan Citizens Committee on Medical Manpower was called for October 16 to spearhead a statewide effort "to produce more doctors of medicine and other medical personnel in Michigan to help relieve critical shortages in many Michigan communities."

The need for a Citizens Committee was discussed by a group of distinguished medical, educational, business, and labor leaders called into session in Detroit by MSMS.

After a unanimous agreement to organize a citizens-committee movement, the group elected Robert J. Mason, M.D., MSMS President Elect, and Warren M. Huff, of Plymouth, long-time prominent leader in Michigan educational and civic affairs, as co-chairmen.

* * *

THE CITIZENS COMMITTEE when formed will include prominent leaders in the field of business, industry, government, labor, agriculture, education, and community service. Regional committees are to be organized on a similar pattern.

The ad hoc citizens group agreed today to accept the evaluation of MSMS House of Delegates that "the quickest, most economical and most effective way to produce more physicians in Michigan is to immediately expand the present two-year medical school at Michigan State University into a four-year, degree-granting medical college."

The MSMS House of Delegates, at its recent annual meeting, instructed that "citizen groups should be established which would take it upon themselves to join the physicians in urging the necessary legislative financial support to meet the demands for more physicians."

* * *

THE HOUSE OF DELEGATES declared that "through the development of the clinical areas of the Michigan State University College of Human Medicine, the State of Michigan can most immediately, effectively and economically qualify the present MSU program as a fully-accredited medical school, and thus with speed and efficiency increase the supply of well-trained physicians so greatly needed to meet the health needs of our rapidly growing population."

Many statistics point up the need to train more physicians in Michigan, declares Robert J. Mason, M.D., Birmingham, MSMS President-Elect, who chairmaned the conference. He said the medical schools at the University of Michigan and Wayne State University graduated 307 physicians this June, leaving Michigan far below the output of many other states. This condition will still hold true if Wayne State and the University of Michigan medical schools expand to their maximums planned — as was also advocated.

MSMS President-Elect Robert J. Mason, M.D., presided at the organizational meeting of the Michigan Citizens Committee on Medical Manpower.

* * *

MEANWHILE THE demand for physicians continues to rise each year in Michigan and the nation, Doctor Mason said. There is a current shortage of an estimated 52,000 physicians in the nation today.

MSU admitted its first class of 26 freshman medical students in 1966 and then added 26 more in 1967 and 26 more this year. The Michigan State Board of Education approved the detailed plans submitted by MSU in 1967 for a degree-granting program.

* * *

THE SECOND EVENT in the new medical manpower appeal was the Conference on Michigan Medical Manpower at the MEA conference center October 23 for physicians, school counselors, college officials, hospital administrators, government representatives, health agency executives, and others concerned with education and medical care. Doctor Mason was the banquet speaker, again stressing the need for a broad citizens effort to help convince the governor and the legislature to move forward the MSU proposal and to plan for the future.

Robert E. Rice, M.D., Greenville, was chairman for the conference.

More details will appear in the November *Michigan Medicine News Extra.*

Five Receive MSMS Certificates

Five Michigan physicians were voted the coveted "Certificates of Commendation" by the 1968 House of Delegates.

In making the report for the House Committee on Certificates of Commendation, Chairman Marjorie Peebles Meyers, M.D., declared:

"The Committee is proud to present for the consideration of the 1968 House of Delegates the names of five distinguished Michigan doctors of medicine for Certificates of Commendation. They are alphabetically, A. Fleming Barbour, M.D., Genesee; Harry A. Clark, M.D., Mason; John M. Dorsey, M.D., Wayne; Fred C. Sabin, M.D., Marquette; and Wilbur D. Towsley, M.D., Midland. Each was nominated by his county medical society, and was considered by the Committee along with other county nominations."

The House concurred.

All were present to receive their awards at the Delegtaes Dinner except Doctor Towsley, whose health did not permit him to travel from Midland. Harry A. Towsley, M.D., a Washtenaw delegate, accepted for his brother. Harry received such a citation himself in 1966.

* * *

Doctor Barbour who has practiced in Flint for 28 years, received a citation which declared:

"In recognition of his inspiring civic service in Flint for more than 25 years, especially with community programs for children, churches, the needy; and also for his excellent leadership in medical and specialty organizations."

Fleming A. Barbour, M.D., right, Flint, who received a Certificate of Commendation, visits with Harry A. Towsley, M.D., left, Ann Arbor, who accepted the Certificate for his brother, Wilbur D. Towsley, M. D., of Midland, who was unable to attend the Delegates Dinner.

* * *

Doctor Clark, who taught medicine from 1919 to 1949 and since has practiced at Muskegon, Ludington and Scottville, received a citation which stated:

"In recognition of many years of inspirational teaching as a professor at the Wayne State Uni-

A Certificate of Commendation was received by John M. Dorsey, M.D., right, distinguished WSU professor, from Speaker James B. Blodgett, M.D., at the Delegates Dinner.

Harry L. Clark, M.D., right, Ludington, received a coveted Certificate of Commendation from Speaker James B. Blodgett, M.D., during the Delegates Dinner.

Continued: Five Certificates

versity Medical School; and in appreciation for continuing medical contributions to the people of Muskegon, and now Mason counties."

* * *

A member of the WSU medical faculty since 1946, Doctor Dorsey received a certificate which read:

"In recognition of his distinguished career as a psychiatrist, teacher and chairman of the Wayne State University Medical School Department of Psychiatry; and his many continuing contributions now to medicine, literature and education as the 'WSU University Professor.' "

* * *

Doctor Sabin, who has practiced at Marquette since 1957, accepted a citation which declared:

"In recognition of his dedicated service as a member of the Northern Michigan University Board of Control and as a member of the Michigan State Board of Registration in Medicine; and as a prominent citizen of Marquette in professional, political, and business circles."

* * *

The citation for Doctor Towsley, who has practiced in Midland for 45 years, read:

"In recognition of 45 years of distinguished service in Midland as a beloved family doctor; and for his unselfish assistance to many medical students, and also to many children and families in need."

Since the Certificates of Commendation were established in 1961, the House has approved four awards in 1962, four in 1963, six in 1964, three in 1965, seven in 1966, and six in 1967.

Fred C. Sabin, M.D., Marquette, received a Certificate of Commendation from Speaker James B. Blodgett, M.D., during the Delegates Dinner.

U-M Med School Tells Changes In Key Posts

Several changes have been made in the administrative staff of the University of Michigan Medical School this fall.

John A. Gronvall, M.D., has been named associate dean to succeed Alexander Barry, M.D., who joined the University of California School of Human Medicine at Davis. Doctor Gronvall had been associate dean and associate director of the University of Mississippi Medical Center.

Robert A. Green, M.D., who has served as assistant dean part time the past year, was appointed to the new position of associate dean for student affairs. The new office of associate dean for academic affairs has been filled by George R. DeMuth, M.D.

Doctor Gronvall currently is director of a national curriculum study sponsored by the Association of American Medical Colleges. He has been closely involved with the development of U.S. regional medical programs. In 1966, Doctor Gronvall was acting dean of the Mississippi School of Medicine and acting director of the Medical Center. A pathologist, he is a graduate of the University of Minnesota.

Doctor Green has been a U-M faculty member since 1958. In his new position he is responsible for liaison activities with schools, colleges, and hospitals; for the review of applications for admission; for counseling; for discipline; and for keeping tabs on the academic and professional development of each of the nearly 800 students on the nation's largest medical campus. Doctor Green has coordinated the special studies program of the Medical School and also is chief of the pulmonary disease section of Ann Arbor Veterans Hospital.

Dean William N. Hubbard, Jr., M.D., explains that the establishment of the office of associate dean for academic affairs reflects the urgent need to revise medical education to respond to new social needs. In that post Doctor DeMuth is responsible for revising the curriculum and promoting research in medical education.

Doctor DeMuth, a pediatrician specializing in pulmonary disorders, has been at U-M since 1956. He has been involved with faculty committees concerned with curriculum, examinations, research, and general educational policies the last five years. He is chairman of the faculty conference on curriculum, and a member of the clinical planning committee responsible for a major part of the new Medical School curriculum.

Ross V. Taylor, M.D., right, of Jackson, and Ralph R. Cooper, M.D., Detroit, are the new leaders for The MSMS Council for 1968-69, elected at the re-organizational meeting at the close of the 1968 Annual Session. Doctor Taylor was advanced from the vice-chairmanship to serve as chairman, and Doctor Cooper was chosen as the new vice-chairman. Doctor Taylor succeeds Robert J. Mason, M.D., who was named by the MSMS House of Delegates as the new President-Elect.

Elect 10 MDs To Shield Board

Ten physicians were among those elected at the 1968 Michigan Blue Shield Corporation meeting to the Shield Board of Directors.

The physicians elected to the board were Brock E. Brush, M.D., Detroit; Eugene L. Freitas, M.D., Detroit; Harold Gehring, M.D., Royal Oak; Homer A. Howes, M.D., Detroit; Philip J. Huber, M.D., Detroit; William B. Jensen, M.D., Grand Rapids; Paul T. Lahti, M.D., Royal Oak; Julien Priver, M.D., Detroit; George L. Reno, M.D., Detroit; Richard E. Wunsch, M.D., Traverse City.

Also elected were Kenneth Boekeloo, Detroit; Laurence A. Hill, Ann Arbor; Frank J. McDevitt, D.O., Livonia; Kenneth Wolz, Saginaw; Victor M. Zink, Detroit.

Elizabeth Crosby, M.D., right, who numbers her medical students in the thousands, was honored by the University of Michigan Medical Center Alumni Society this month for outstanding service. John Goodsell, M.D., Saginaw, president of the Alumni Society, presented the certificate to Doctor Crosby. Also saluted was Mrs. Dolores White, center, long-time assistant head nurse at University Hospital.

Vernon V. Bass, M.D., left, Saginaw, Chairman of MDPAC, visits with the two congressmen-speakers after the annual MDPAC Breakfast. Congressman Donald Riegle serves the 7th Congressional District of Genesee and Lapeer counties, and Congressman John Conyers, Jr., serves the 1st Congressional District, covering a portion of Detroit and all of Highland Park.

Kellogg Fund Finances More Studies By State Board about Health Care

A grant of nearly $100,000 was made recently to the Michigan State Board of Education by the W. K. Kellogg Foundation of Battle Creek to help finance studies of educational programs in medical and allied health fields.

The money, which totals $98,680, will be used to continue the work of the State Board Advisory Committee on Education for Health Care.

State Board of Education President Edwin L. Novak of Flint said the grant will be used to subsidize salaries of the committee's staff for two years, providing for a project director and assistant, two researchers and staff travel as well as office equipment and supplies.

"We are indeed pleased that the Foundation in recognizing the important work of this committee has given so generously to support its efforts," Novak said.

THE 17-MEMBER COMMITTEE was organized in April, 1966, and charged with studying educational implications of health manpower needs in Michigan and making recommendations to the Board concerning educational preparation of such manpower.

It hopes to accomplish its goals in a three-phase program:

1. An inventory of health care manpower in Michigan, including an inventory of the educational programs for the preparation of such manpower;
2. Development of a plan to provide educational facilities and programs necessary to meet the needs for health care personnel in Michigan;
3. Further studies and research which relate to findings and recommendations of Phase I and II.

Three advisory groups report directly to the Citizens Committee. The first, called the General Advisory Committee, is charged with taking a "functional approach" to health manpower needs, and is staffed on the basis of individual qualifications of members, rather than professional or institutional affiliations.

THE OTHER TWO subcommittees report directly to the General Advisory Committee. The Advisory Committee on Medical Education is composed of medical doctors and osteopaths, and the Advisory Committee on Nursing Education is represented by professionals in the field of nursing. Both subcommittees provide technical assistance and data from their respective areas and recommend programs to fill manpower shortages.

These recommendations are then included with other reports compiled in related health fields and submitted to the Citizens Committee. Before being submitted to the State Board of Education, the reports are reviewed by the Citizens Committee and evaluated in terms of cost, compatability, political implications, etc.

The flow may also be reversed. When an institution of higher education requests sanction from the State Board for establishing academic programs in health-related vocations, the Board often asks for study and recommendations by the Citizens Committee before taking action.

A COMMITTEE STUDY of schools of medicine in the state led to the recommendation of a four-year School of Medicine at Michigan State University. The committee has also made significant recommendations on the needs of osteopathic medicine in the state and has set up a system of priorities for new medical schools. It is currently studying a proposal to establish a College of Osteopathy in Michigan.

The Committee conducted a survey of applicants and admissions to associate degree nursing programs and has worked closely with many health-oriented agencies and organizations, such as the Michigan Association for Regional Medical Programs, the Comprehensive Health Planning Commission, the Manpower Task Force of the Vocational Rehabilitation Comprehensive State Planning Project, the Human Services Occupations in the Department of Mental Health, and others.

It is currently compiling the final report of Phase I, which surveyed the supply and distribution of manpower in a wide variety of health professions and occupations as well as the education programs for the preparation of such health personnel. Preliminary findings and recommendations are divided into two areas: (1) general recommendations relating to the need for trained manpower in a wide gamut of health careers, the need for continuing planning and coordination to meet these needs, means for implementing such planning, and the role of the institutions of higher education in meeting the needs for trained manpower in health fields; and (2) specific recommendations relating to particular occupational areas, e.g. medicine, dentistry, nursing, medical laboratory services, etc.

ALTHOUGH ADDITIONAL recommendations and slight alterations may occur in the final draft, the preliminary report includes the following conclusions:

1. Primary responsibility for the development and administration of educational programs in the health care area should be carried by educational institutions.
2. Where clinical experience is an integral part of education for a health profession or occupation, such experience should be under the control of the responsible educational institution. The health facility providing such clinical experience should be reimbursed for such educational costs as instructors' salaries, stipends, teaching materials, etc.
3. Preparation of qualified faculty must take high priority in the development of educational programs in the health area. Shortages of competent faculty in many teaching areas emphasize the need for careful planning for expansion of existing programs and establishment of new programs to ensure the most effective use of faculty resources.
4. The impact of new knowledge and technology in the health care field will require innovations in curricula of programs preparing health personnel. It is particularly important in setting up new educational programs that sufficient flexibility be built in to take account of anticipated changes in the role of the particular health profession or occupation.
5. The university medical centers should assume a leadership role in the development of educational programs in the health area in the dissemination of research findings and in the continuing education of health personnel. These efforts should be coordinated through the Michigan Association for Regional Medical Programs.
6. Universities with medical centers or with considerable strength in the biological and physical sciences should consider developing interdisciplinary programs in the preparation of allied health personnel. Such Schools of Allied Health Professions have already been established in a number of states.
7. Reciprocity between community college districts is needed to implement regional planning for education of allied health personnel.

IN ADDITION TO working on a state plan for adequate health care education facilities, the Committee in the next two years will help develop demonstration projects in allied health education such as medical technology and para-professional fields.

Other areas of Committee concern may be establishment of a statewide health manpower data bank, the licensure and registration of health professionals, the development of a core curriculum in health sciences for community colleges and new curricula for evolving health technologies.

The Committee also will consider recruitment programs to interest young people in the health professions and to reactivate existing trained personnel who have left health careers.

AMA Invites You . .

MSMS members, when they are in Chicago, are cordially invited to visit the AMA Headquarters at 535 N. Dearborn.

Last year, nearly 900 persons toured the AMA building. The AMA extends a warm welcome to all physicians, their wives and guests to take a 40-minute tour to become better acquainted with the AMA's organizational structure, its major areas of activity and some of the numerous services available to physicians, as well as the public. Tours are given between 9:00 a.m. and 4:00 p.m., Monday through Friday.

Doctor, Your Shield Is Showing

BY LELAND E. HOLLY, II, M.D.
MUSKEGON

It appears appropriate that the record and future of Michigan Blue Shield should be reviewed. Certain of the specific observations and associated criticisms that have in the past been very pertinent can now stand only as matters of record. As such, however, they may be important at the next point in time when a review is again seen to be desirable. That time will come.

Blue Shield: The Doctors' Plan?

All advertisements say it is. The Michigan State Medical Society started Blue Shield in 1931. Further, the doctors of Michigan even reduced fees in the 1940's to "save" the plan from bankruptcy.

Blue Shield inception and growth has always been directed by the Blue Shield Board of Directors. Physicians have always been in the majority on this board. While this representation does not in any way indicate that Blue Shield direction was or is given by a concurrence of the majority of the physician directors, it has cemented the idea of a "doctors' plan" in the thoughts of the public.

The M-75 plan, with fee level tied to income classification, was touted as representing the physician's classic approach to charging fees, and was given near unanimous support by the Michigan State Medical Society.

In 1966 the Michigan State Medical Society changed tacks, and in resolution No. 29 the House of Delegates provided for establishment of the concept of reasonable, customary and prevailing fees. Again, we have a "doctors' plan."

If there is still doubt in your mind, answer the question, "Who will be blamed if Blue Shield fails?"

Blue Shield Views Itself

In 1931 Blue Shield was born in Battle Creek in a time of great economic deprivation. It was a time of great public and professional need and Blue Shield played the role of guardian savior to lay and professional alike.

President McCabe recently described the purposes at that time, ". . . Blue Shield would not be a commercial enterprise, an 'economic undertaking,' but would be a means of service alone, with free choice of physician, with limitation of benefits to service, with exclusion of profit."[1] President McCabe went on to say that the first plan offered would provide, ". . . in effect, comprehensive full prepaid medical care in home, in the physician's office, in hospital."[1]

In 1968, at a time when public and professional needs may be of greatly different character than in 1931, President McCabe said of the early ideals, "The goal was right. The know-how was not."[1] "It seems to me," said Mr. McCabe, "that this can be crystallized very simply to provide a mechanism substantially which sustains and maintains the desirable elements of the private practice of medicine in such a way as to make available quality care at the lowest possible cost."[1] Mr. McCabe also states, "Blue Shield must be the answer."[1]

Blue Shield as a "Savior"

There is good reason that Blue Shield would have doctors continue to believe in its role as the guardian and savior of medicine and the public. Physicians should remember, however, that a bankrupt Blue Shield and the public were "saved" by medicine in the fee-cutting days of the 1940's, and that a dying Blue Shield is again being rescued by physicians' approval of the Michigan Variable Fee. To accept both the thought of being "saved" and "saving," physicians are led logically and inescapably to the conclusion that they have been and are saving themselves and the public with their plan.

James E. Appel, M.D., of the AMA can be quoted, third hand, as follows: "The voluntary establishment of reasonable income ceilings is the only protection the profession has against governmental price controls."[1] While financial woes were the danger in the past, the new threat is government control. Physicians again find themselves preparing to "save" themselves and the public.

In this confusion doctors lose sight of the fact that Blue Shield is for all effective purposes a totally separate entity and could be totally independent of organized medicine. Consider, for example, its third-party role in Medicare.

Blue Shield and Quality Care

The main thread of the Blue Shield idea is to make quality care available at the lowest possible cost. It must be presumed that Blue Shield refers to high quality care. Consideration of the cost aspect can be postponed for the moment.

Unclear is how Blue Shield is to insure the height of the quality. Our state medical society has the means to control the quality of medical care and, in fact, does exercise the controls without regard to Blue Shield or any other insurance, governmental or lay program. The guarantee of high quality medical care is our moral and ethical obligation, and our right alone. It is not a right we have delegated to any lay party. Or have we?

Direct and indirect controls must be exercised in order to guarantee the patient his service and the doctor his fee. To the public "participators" are "good guys" and "non-participators" are "bad guys," and, somehow, the stamp of "quality care" is attached to the services of the former. Blue Shield emerges as the "protector" of the innocent sheep among the wolves.

Blue Shield and the Elimination of Profit

That the Blue Shield insurance business should make medical care available at the lowest possible cost and not make a "profit" has been clear from its beginning, but Mr. McCabe says "Doctors must pass on to the patients some of the savings resulting from increased productivity, especially as the amount of free service diminishes."[1]

Just what percentage of billings turns out to be "free service" in the physicians' experience? Does this percentage of "free service" apply to all doctors or to just a few? How much of the "free service" is reduced by the Blue Shield program? Is the number of "free patients" cared for by most doctors sufficient to make any difference in physicians' charges to other patients? Regardless, since 1957 it appears Blue Shield has extended the concept of no "profit" to physicians' fees.

Every physician must determine this for himself since what may be true for one physician or in one area may not be universally true. The fact remains, however, that the Blue Shield program between 1957 and 1968 went beyond the concept of a non-profit business venture when it passed on "savings" to patients by restricting professional fees to a level which it, in effect, had determined.

Blue Shield and Two Fee Schedules

Through the years under the cover of M-75, "the doctors' plan," this unreasonable Blue Shield fee restricting activity has made a double fee schedule necessary for many "participating" physicians. It has meant non-participation for many more. These physicians came to feel that the favorable premium rate Blue Shield subscribers enjoyed, supposedly generated from an effective, efficient, non-profit insurance system, was simply a reflection of the inadequate fees allowed. Some physicians have suggested that the unique and onerous clerical requirements of the Blue Shield program should actually justify a surcharge.

On the other hand, the existence of such a double fee schedule for "participating" physicians and non-participation by many others has been construed by some patients and public to mean that the honest fees of these physicians are prima facie evidence that they have "profited" off private-pay patients and unfavored insurance companies. This certainly is a logical deduction when it has long been and continues to be Blue Shield's assumed duty to determine a physician's "valid"[1] fee and its "normal evolution."[1] After all, it is the doctors' plan, isn't it?

It has been said that the existence of inequitable fees is not Blue Shield's doing, and that other factors and people have been involved since 1957. Is it just the insurance commissioner, or were other identifiable influences also at work? If the cost of living rose 20 per cent by 1971 could physicians' fees be changed accordingly?

The desirable elements of the private practice of medicine seem to include the preservation of the right of the physician to set his own high

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standards of care and also his own fair fee. If physicians have given up any part or all of these rights, directly or indirectly, they should know clearly why, the extent, and to whom. Given up they are, but the terms are unclear to most physicians.

Blue Shield Keeps Fees Down

To the extent that the extra clerical work Blue Shield requires is done in every doctor's office and hospital at no expense to Blue Shield and to the extent Blue Shield benefits are less than a physician's honest compensation, medical costs are held down.

Mr. McCabe has seemingly ignored other factors when he said, "Consider non-participation from an impersonal point of view. I have no doubt that should non-participation be large there will be inevitable and rapid escalation of fees, for such is the nature of economic pressures, no matter how high may be our resolves."[1]

Certainly, Blue Shield should recognize that economic pressures are a valid reason for raising fees. Blue Shield certainly should also recognize that 95 per cent of the physicians are conscientious, honest, reasonable, cooperative, and, believe-it-or-not, sensitive to patients' and Blue Shield's problems with bills. Or isn't physicians' economic welfare important? Or aren't 95 per cent of physicians honest?

That there would be a "rapid escalation of fees" is an assumption on the part of Mr. McCabe which may or may not be true. Historically, it certainly has not been and some examples quoted from an actual fee schedule of several years ago, compared to those more current will lend credence to an opposite viewpoint.

1934 - Ordinary day visit (7 a.m.-10 p.m.) [away from office]	$3.00-$5.00[2]
1959 - 003 Home, First Visit	$7.50[3]
005 Hospital, First Visit	$10.00
Subsequent Visits	$4.00
1967 - 9001 & 9009 Routine limited visit at home	$12.50[4]
1967 - 9601 Initial Hospital Visit	$15.00[4]
Each day for 20 days thereafter	$5.00
1934 - Appendectomy	$125.00-$250.00[2]
1959 - 3261 Appendectomy	$105.00[3]
1967 - 3261 Appendectomy	$175.00[4]
1934 - Chest - Heart	$10.00[2]
1959 - 7100 Chest, PA	$10.00[3]
1967 - 7100 Chest, PA	$10.00[4]
1934 - Pyelogram, Intravenous	$15.00-$20.00[2]
1959 - 7372 - Pyelography, Intravenous	$30.00[3]
1967 - 7372 - Urography, Excretory	$35.00[4]
1934 - Wrist x-ray	$5.00[2]
1959 - 7256 - Wrist	$10.00[3]
1967 - 7257 - Wrist	$10.00[4]
1934 - Cystoscopy, Hospital	$25.00-$50.00[2]
1959 - 3931 - Cystoscopy, Diagnostic, initial	$15.00[3]
1967 - 3931 - Cystoscopy, Diagnostic, initial, hospital	$50.00[4]

These examples, admittedly not comprehensive, indicate a very strong tendency on the part of physicians to hold fees down and to pass on the rewards of increased productivity to the patient. Where increases seem large is where overhead expenses such as wages, equipment and rental rates are greatest (up to 70 per cent), or where the service is not comparable.

Is credit for this remarkable record to be assumed by Blue Shield?

Blue Shield Recognizing Its Ills

Of M-75, a program that was hoped would cure Blue Shield's problems, Mr. McCabe has said, ". . . as you and your patients become increasingly irked by these fixed-fee levels and patient income classifications, by such things as slow recognition of specialities, by all the signs of what you might call obsolescense of what you and Michigan Blue Shield had devised, medicine and Shield went back to that original search for common effort for common cause."[1]

A great majority of Michigan State Medical Society physicians were willing to admit many years ago that M-75 had been a mistake, but the clamor that arose for correction got no response for those many years. It does not appear, therefore, that 11 years of progressive deterioration came about because the doctors wanted it that way. It appears that the major culprit may be hopefully seeking someone to share the burden of guilt.

It is probably fair to say that Blue Shield inertia has been caused in part by the Michigan State Medical Society's failure to direct and insist upon coherent, in-depth studies of, and solutions for, current and future socio-economic and health needs. Nor has the Michigan State Medical Society demanded clear correlation between Blue Shield's words and deeds. As an example, it is only necessary for physicians to consider the following statement of Mr. McCabe, "As I have said, we do not intend to force doctors to spend their time shuffling paper. Your business is rendering medical care."[1] Or a physician can consider another quote from Mr. McCabe, "May I quickly add that I believe that your experience with Blue Shield in present review procedures, both in connection with this and in the matter of determination of reasonableness of fee, mentionad a few minutes ago, has shown you that we at Michigan Blue Shield **have** and intend **to continue to cooperate** fully with the profession in such matters."[1] Some physicians would be rather definite in stating that for 11 years considerable paper shuffling has continued unabated, perhaps even enhanced, along with growing uncooperation and unresponsiveness on the part of Blue Shield.

Apparent acceptance over the years of the Blue Shield program in southeastern Michigan, without suggesting that this acceptance is not based on the informed desire of area physicians, has played a tremendous role in justifying the continuation of Blue Shield and the apparent inertia of its dynamic growth and maturation over the last ten years.

A Recommendation to Blue Shield

From a truly doctors' insurance program, as Blue Shield professes to be, physicians should not expect:

1. Immediate changes in policy after such have been recommended by physicians.
2. A program which ignores individual physician dishonesty or fails to have a means to guard against it.
3. A program to pay "way out" charges without realistic examination.
4. A program which will respond to vituperative, stubborn, disinterested, selfish, nonconstructive non-cooperation.

But doctors should expect to enjoy:

1. As great a simplification of billing as modern technology can provide.
2. Development of an effective, efficient system for redress for all parties in the insurance program.
3. An effective system for constant program modification as economy and medical advance dictate.
4. A current fair and reasonable variable fee adjusted each year or at similar reasonable intervals.
5. Prompt, essentially unquestioning payment for services.
6. A favorable image presented for all physicians, regardless of whether they are "participating" or not.
7. Fair, friendly, and tactful dealing with physicians without threats of harassment.

In return physicians should provide:

1. Proper identification of the service.
2. A record for the reason for the service.
3. A reasonable charge for the service determined by good practice under the circumstances.
4. Complete identification of the recipient of the service.
5. Availability of record for confidential and actuarial use of the carrier and for surveys to determine veracity of providers and consumers.

Blue Shield Curing Its Ills

Blue Shield has come up with its new Michigan Variable Fee program (MVF). This new program is said to guarantee a physician his usual and customary charge providing it is reasonable. Mr. McCabe asks, "Realistically, who can object? There are adequate provisions for payment outside range for unusual circumstances and procedures."[1] Such a promise for the variable fee program seems to fly in the face of past experience.

Mr. McCabe says, further, "As I see it, it is a simple question of working cooperatively and positively together in the development of the techniques needed to reach a common cause."[1] All physicians must agree with this but they must also note that if the doing is as simple as the asking, and if there had been a lot more of the former, the grand promise of reaching the "common cause" might have more substance.

As to the promise of the physician's reasonable and customary fee, the words are nice, but the promise may be empty when analyzed. "Profiles" or "prevailing fees" can have no meaning from Blue Shield experience to date since there has been no adequate, modern, complete standardized reporting of services in the absence of a common coding and nomenclature system.

Among other things the "prevailing range" of the new Michigan Variable Fee program is dependent upon community size and area in the state according to "exact differences in such fee determinants in the past."[1] In the absence of a uniform state-wide reporting system, presuming no other deficiencies in the statistical data of Blue Shield, the existence of such exact determinants is open to serious question.

A customary fee may be altered on 90-day notice. "Action will be immediate."[1] Even though the request be denied as being outside of the prevailing range, the factor of a request for alteration ". . . itself will tend to extend the prevailing range, in standard statistical method."[1] Historically, "immediate" is subject to wide interpretation by Blue Shield. And just how the standard statistical method operates in the Blue Shield situation is obscure.

Do physicians have clear knowledge of how they can alter their fees; can they have clear expectations that this alteration will be accepted? Can a raise in fees above the fair and reasonable fee for 1968, as determined by Blue Shield, both as to amount and timing, ever be accomplished without approval of big industry-labor, the insurance commissioner or others?

To date the new MVF program has been woefully inadequate in meeting effectively, much less efficiently, many of the requirements of any reasonable insurance program.

Who's in Control?

Given the Blue Shield program, doctor control is of paramount importance, but it is not attainable through the Blue Shield Board of Directors, nor with any certainty through the House of Delegates as the Blue Shield corporate body. In those two groups there is only doctor **influence.** Any absolute control is diluted by the many outside forces which are usually non-medical.

Unless doctors act as a nearly unanimous group of non-participating, non-assignment-taking providers, or act on nearly unanimous recommendation for dissolution by the House of Delegates of the Michigan State Medical Society as the Blue Shield Corporation, the Blue Shield insurance program will continue to function with doctors' control greatly diluted. There does not appear to be a middle road.

There is very real and justified confusion as to whom the Blue Shield creature belongs — big industry-labor or the Michigan State Medical Society. We know to whom everyone thinks it belongs, and at whose feet blame for difficulties will be laid. But Blue Shield fees and service benefits are tied to industry-labor negotiations with no guarantees of acceptable adjustments as they may be desired by the medical profession. There is only an unspecified promise, unbacked by past performance, of a dynamic insurance program which will keep pace with the times medically and economically. Can physicians believe this is possible if the real control lies with industry-labor or some other faceless group?

We are asked to accept this promise only because Blue Shield needs us. But what have they shown to warrant such trust? For ten years the Blue Shield program has been extremely unresponsive to the needs of the medical profession. It is not practical for physicians to accept another ten years of the same, or, for that matter, even three years.

Such inability of Blue Shield to respond particularly to unique or varying provider situations, unless the provider has been of the stature of large institutions not generally found in out-state Michigan, should be a matter of great concern. The signature of approval on the participation agreement of the individual "little man" physician working for his patients by himself is certainly very trusting. It is questionable if his consent to "participate" is informed.

The dilemma of the individual physician who wishes to practice non-participation is pointed up by the implication of Mr. McCabe's words when he states, "I am afraid it [per case participation] may successfully deter full participation and will be looked upon by those in our community who we must also satisfy — those who pay the bill — as an indication that the medical profession is unwilling to be cooperative, is unwilling to even subject itself to the administrative jurisdiction of an organization in which it plays a major role — in fact, the significant policy-making role."[1] It appears clearly implied that the independent physician may be considered some form of pariah if he does not cooperate.

Doctor Approval Is an Act of Faith

It appears quite definite that most Michigan physicians signed the agreement to participate in the Blue Shield Variable Fee program. If this were not the case, it cannot be conceived that large corporations would purchase this kind of insurance for their employees. It is also certain that the management group, as well as the employees, expect that the employee will not have to pay a cent for any medical service he receives once the no-member-liability rider is attached (as it is in many cases). Such a program could not have been honestly offered without significant and probably preponderant cooperation from Michigan physicians.

All physicians know who the provider is. All physicians think they know who the consumer is but it is quite apparent that they do not know him well. Physicians know only their patients who are merely one part of the consumer body. The other part may be industry-labor, big government, large pressure groups, or even small effective minority groups in industry, labor, society, or medicine. To these others Blue Shield may be a means to control physicians!

Physicians must be advised that acceptance of the new MVF is an act of faith. Unless the honest expectations of almost every physician in this state have been identified and met, and unless their emerging expectations are met as these expectations in time become the majority, the physician's faith will have been betrayed. He has given up his rights and duties for naught.

Unlike a machine which operates as directed, the Blue Shield program is a creature which may act independently. Such a creature requires far more strength and far greater surveillance than a machine for proper control. It is doubtful that organized medicine can ever act with the unity necessary to provide this strength and surveillance. The characteristic individuality of physicians may prevent adequate control ever being realized. Careful and close adherence to clearly defined and understood first principles are necessary but does not appear practical under the circumstances.

Doctor, your Shield is showing. What will you do about it?

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WHERE WE'D BE WRITING COPY

From the East Jordan News-Herald

"We like the imagery of our enterprise, white knight of freedom, last bastion of individual rights, guardian of Democracy, and the rest of the cliches which at one time or another have been used in describing the role of the "fourth estate."

"And so it's with a bit of trepidation that we offer our commentary concerning at least one aspect of the status of the medical profession—or the "first estate."

"Today, many small communities are without the services of doctors—and this phenomena appears as a growing trend.

"By population statistics and other distributive comparisons, these communities are entitled to medical service—one and sometimes as high as a half dozen doctors.

"YET, THEY HAVE NONE.

"And, by contrast, other communities may be over-blessed with medical men. The per capita ratio gyrates wildly from city to city or even between adjacent communities.

"In each instance, there may be reasons for these differences in the amount of medical service available.

"This may be due to the presence of an outstanding hospital; an outstanding clinic; the location of the community or its particular assets; the cooperation of local merchants and civic leaders in creating an amiable medical climate.

"These are just a few of the reasons that one community of 4,000 people may have 6 or 8 doctors while another community of 4,000 has one doctor, or none.

"The medical profession itself has recognized this disparity in medical placement and has sought by its own enterprise to place doctors where they are needed—through voluntary placement agencies that try to help new doctors in locatiing.

"BUT SUCH AGENCIES can only do a certain amount. Frequently, legislation may be against them—such as it is here in Michigan where future practitioners must pass a lengthy basic science exam. This requirement contributes to the doctor shortage in Michigan by putting up a bar against doctors from other states who might want to settle here since such examinations require a long brush-up period for the doctor who has been out of school for five to ten years—when he is really at the peak of his efficiency.

"However, if the inequitable distribution of doctors continues to develop along its present patterns, it would seem inevitable to us that some day Big Brother will start dictating the assignment of physicians.

"This would be reprehensible.

"However, since the constitutionality of individual rights seems to be set in terms of political expediency in our modern world, it would be difficult to predict what might happen—if Big Brother starts meddling again with medicine (witness our clogged hospitals and spiraling medical costs since Medicare started).

"The justification for governmental placement of physicians might be established on the basis of a general philosophy that since the state supports medical schools with tax dollars, it should have a voice in regulating some of the affairs of those who have benefited.

"IF THAT SHOULD ever take place, total regimentation of the entire populace could then follow. The government, by the same reasoning, could start ordering teachers to where they might be needed, engineers to certain type of projects.

"In short—anyone who had ever accepted a cent of educational subsidy, directly or indirectly, would then become a pawn in the affairs of government.

"And we can't help but close this thought for the week with facetious observations that if such a sorry state of affairs ever transpires, even newspaper editors who had trained at a public university could also be ordered to a duty assignment. With a certain insight as to our own status in the eyes of Big Brother, there's a good possibility that we'd all be typing copy in Hell."

BLUE SHIELD PRESIDENT SAYS:

Private Sector Can Meet New Health Care Demands

BY MICHIGAN MEDICAL SERVICE

"The private sector has the capability to meet the demand for increased medical care within a sound economic structure without government intervention," John C. McCabe, president of Michigan Blue Shield, told Michigan physicians at the annual meeting of the corporation, Sept. 24 in Detroit.

The members met in conjunction with the annual convention of the House of Delegates of the Michigan State Medical Society.

"Medical care will cost more — because it will be worth more," Mr. McCabe said, "just as it is worth more today than yesterday."

"However, I believe that the incremental costs will not be abusive. I am convinced, as well, that we will be able to work together to see that this will be true."

The Blue Shield president said much current criticism of private medicine comes from those "who are less concerned with correcting what they call the faults of the Medical economy than they are with redesigning it to suit their own philosophical views."

Mr. McCabe declared:

"There are those who feel that the situation calls for less continuity and more change and that the problems are such that radical redesign is the only answer and that revision and readjustment will be ineffective.

"The contrary is true. Crucial to our success is a benefit program to which maximum physician cooperation has been committed. Only through a more nearly total physician participation can we assure the public and the large group customer — as well as the critical in and out of government — that our subscribers will be able to receive services with a minimum of difficulty, with an assured level of quality, and at a cost which is equitable for the physician and reasonable for the public."

Mr. McCabe said the growing demand for more pre-paid medical service in the private sector is reflected by increasing enrollment. By July of this year Blue Shield was serving more than 5,536,000 people in its program — 63.6 per cent of the State's population — and its subscription income, excluding government business, has reached the $150,000,000 a year level and will achieve a $175,000,000 rate next July.

Blue Shield will pass the 8,000,000 claims per year mark this year, Mr. McCabe said, and will pay 10,000,000 claims in 1969. In 1970 the figure will rise to nearly 20,000,000 he said.

Mr. McCabe reported that Blue Shield's Conversion to its MVF, or Michigan Variable Fee program has passed the million member mark and will have been extended to more than 3,500,000 persons, or 80 per cent of non-government Blue Shield membership, by the end of 1968.

The program is designed to meet virtually all medical care costs without regard to patient income.

Discussing other operational activities for the first half of 1968, Mr. McCabe said that Blue Shield employs 1,343 people, more than 33 per cent higher than in the summer of 1967, "and three and one-half times what employment was when I came to Blue Shield less than three years ago."

The growth has forced major systems revisions and development of new computer techniques, Mr. McCabe noted, and innovations such as new plastic coated membership cards now being manufactured for use in "charge plate" techniques to eliminate most paper work and speed service.

It has also resulted in need for the new joint Blue Shield-Blue Cross service center complex to the west of the Chrysler Freeway north of Jefferson.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Adnan Alshbkhoun, M.D., 33100 12 Mile Road, Farmington 48024
Joseph F. Burtka, M.D., 16505 John R. Street, Madison Heights 48071
Mary L. Marshall, M.D., 1389 W. Maple Ave., Adrian 49221
Evangeline D. Mojica, M.D., 140 Elizabeth Lake Road, Pontiac 48053
Pablo A. Mojica, M.D., 140 Elizabeth Lake Road, Pontiac 48053
William J. Passinault, M.D., 26 Sheldon Ave., S.E., Grand Rapids 49502
Everton Quadros, M.D., Blissfield 49228
J. Patrick Quigley, M.D., 31815 Southfield Road #14, Birmingham 48009
Leif G. Suhrland, M.D., Dept. of Medicine—MSU, East Lansing 48823
William H. Swartz, M.D., 2335 S. Commerce Road, Walled Lake 48088

Explain How Medicare Patients Will Pay 10% More in 1969

Examples of how the 10 per cent increase will effect Medicare beginning January 1. The 10 per cent increase in the amount that patients will pay for hospitalization under Medicare was announced in September by Wilbur J. Cohen, secretary of HEW.

Following are some examples:

A patient now pays the first $40 of his hospital bill, Medicare covering the balance thru the 60th day of hospitalization. Beginning Jan. 1, the patient will pay the first $44.

The patient pays $10 a day from his 61st to his 90th day of hospitalization. This increases to $11 a day, with Medicare handling the balance.

The patient pays $20 daily for the next 60 days. This will be raised to $22.

Should the patient enter a nursing home after hospitalization, his first 20 days of care are free of charge. After that he pays $5 a day from the 21st day to the 100th day, with Medicare taking care of the balance. The $5 rate increases to $5.50 a day.

Cohen attributed the rate rises to increasing hospitalization costs, which he blamed on "a multiplicity of reasons." He said a hospital stay of an elderly Medicare beneficiary averages about $600.

SAFETY TIPS

Wearing a seat belt would have saved 40 percent of those killed in highway accidents, University of Michigan safety research shows.

Driving with bald or worn tires at high speeds on wet concrete is like driving on ice, according to the University of Michigan Highway Safety Research Institute.

LAUDS NEWS EXTRA

Michigan Medicine's newsletter was recently given recognition by an American medical society executives association study.

The front page of a recent issue was reproduced in the organization's newsletter with the comment:

"Michigan's eight-page brown ink on blue paper is a quality production using bleed-offs and an interesting variety of articles. Along with the careful placing of articles by their importance, the issue is used to stress a particular coming event."

Work is proceeding on the new $24 million Basic Science Building of the Wayne State University Medical School. The building, which will be only slightly smaller than Cobo Hall, will have a total area of 482,510 gross square feet. The teaching-research facility, at the southeast corner of Canfield and Brush, will help make it possible to increase the WSU medical school class from 125 to 200.

AMA Official Describes Primitive Viet Facilities

American physicians are shocked by the primitive facilities at provincial hospitals in Vietnam, said Malcolm E. Phelps, M.D., AMA Vice-President and former chief of the "Volunteer Physicians for Vietnam" program, at an anniversary luncheon of the Michigan Health Council recently. "Some places we have a microscope, some places we don't," he continued.

Sixteen million South Vietnamese civilians have only 158 practicing native doctors and 1,800 hospital beds. These beds are often occupied by two, three, or four patients, while others are bedded on the floor, Doctor Phelps said.

Tuberculosis, he reported, is the most prominent disease, and most of the people have intestinal parasites. Opportunities for disease observation are unlimited, the AMA Vice-President said. "I can show you acres of anything you can name."

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Corrective Action Needed

Any improvement in the public relations of the physician and the medical society must be earned through the day to day conduct of each physician in his private practice. The remaining time is short and the need for corrective action is now. The image of the modern physician must be projected as that of a highly trained scientist who also possesses an understanding heart; a master of the heart as well as the science of medicine.

—Charles E. Farber, M.D., President,
Kent County Medical Society
Excerpts from "President's Message,"
Bulletin of the Kent County Medical Society

ANDERSON TO HEAD U-M HEALTH SERVICE

Robert E. Anderson, M.D., formerly of Flint and now of Ann Arbor, is the new director of the University of Michigan Health Service. A graduate of Michigan State University and the University of Michigan Medical School, he has been a member of the U-M Health Service staff since 1966. Doctor Anderson is a Fellow of the American School Health Association and the American College Health Association and a member of the American College of Sports Medicine.

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Mental and Public Health Expenditures For State Reported

Several observations may be made from a study of the three accompanying tables and other data in the *Michigan State Economic Record.*

The following notes are observable from the data:

1. State expenditures on mental health have increased from $34,671,000 in 1950 to $122,674,000 in 1967, or a 254% increase over the 18 year period.

2. State expenditures on public health have increased from $16,791,000 in 1950 to $36,119,000 in 1967, or a 115% increase over the 18 year period.

3. The allotment of funds for mental and public health purposes, although constantly increasing over the years, has maintained a rather constant percentage of total state expenditures (6% and 2% respectively).

The Detroit Maternity and Infant Care Project, funded in 1964 under a U.S. Children's Bureau grant to the Detroit Department of Health, gives maternity and infant care services for high risk medically indigent families. The staff, directed by William F. Goins, M.D., has given care to approximately 3,000 patients. The above photo was taken at one of the six hospital clinics.

4. Percentage changes in mental and public health expenditures seem to be on the upswing in the latter sixties with greater gains being made in the mental health area.

It should also be noted that the 1968 schedule of state expenditures shows no significant change in past trends in the mental and public health fields.

These three tables are from *Michigan State Economic Record,* Vol. 10, No. 4.

TABLE I
STATE EXPENDITURES
(in thousands)

Year	Mental Health	Public Health	Total Expenditures** (all functions)
1950	$ 34,671	$16,791	$ 556,519
1955	45,860	20,270	757,846
1960	71,681	25,422	1,107,786
1961	75,957	23,698	1,175,138
1962	81,517	25,652	1,243,830
1963	83,475	25,556	1,306,335
1964	87,206	29,296	1,405,490
1965	93,974	31,293	1,535,996
1966	104,632	35,780	1,822,255
1967	122,674	36,119	2,194,257

Table I shows the actual dollar amounts spent on mental and public health in Michigan for 1950-67

**includes mental health, public health, education, highways, public welfare, general government, public safety, and other expenditures.

TABLE II
PERCENTAGE OF TOTAL EXPENDITURES

Year	Mental Health	Public Health
1950	6%	3%
1955	6%	3%
1960	6%	2%
1961	6%	2%
1962	7%	2%
1963	6%	2%
1964	6%	2%
1965	6%	2%
1966	6%	2%
1967	6%	2%

Table II shows the percentage of total expenditures allocated to mental and public health in Michigan for 1950-67

TABLE III
PERCENTAGE CHANGE OF MENTAL AND PUBLIC HEALTH EXPENDITURES

Year	Mental Health	Public Health
1950	—	—
1955	3%	2%
1960	6%	2%
1961	6%	−7%
1962	7%	8%
1963	2%	.4%
1964	4%	14%
1965	8%	7%
1966	11%	14%
1967	17%	.9%

Table III manifests the yearly percentage changes of mental and public health expenditures in Michigan for 1950-67.

Marriage Rate Up, Predict New Population Boom by 1978, or Sooner

The Health Insurance Institute reports the United States may soon be in the midst of another population explosion. Current estimates indicate a new baby boom can be expected within five to ten years or possibly sooner.

Total births in 1967 were 3,533,000, almost 100,000 fewer than the previous year. However, professional demographers say that there will be a record number of babies born in the 1970's, with a good chance that the population will double and reach 400 million persons by the end of the century.

The rise in marriages to 1,913,000 in 1967 is one indication that the predictions may be true. Also a new crop of eligible husbands — young men between 21 and 24, in short supply since 1956, are now coming of age.

The Institute further notes that despite the use of birth control pills, the size of families will not necessarily be reduced. The pills are frequently used to allow couples to space their offspring more conveniently.

Irregardless of the pattern of fluctuation, the Institute says the traditional peak baby months of summer are expected to continue. During July, August, and September of 1968 about one million babies are expected to be born in the United States.

Physicians interested in more details can obtain *Health Insurance News,* May 1968, published by the Health Insurance Institute, 277 Park Avenue, New York 10017.

STATE BUSINESSMEN FAVOR TAX CREDITS TO HELP ENCOURAGE REMODELING

The National Federation of Independent Business reports that 63 per cent of the Michigan businessmen who answered a survey favor HR 17252 introduced by Representative Hale Boggs to allow property owners to deduct a part of their costs of renovating old buildings from income tax returns.

The Michigan survey found 32 per cent opposed to the Boggs bill, and five per cent undecided.

The Boggs anti-slum legislation would allow property owners to deduct a portion of money spent to recondition old buildings provided that their usefulness either for rental or business purposes is improved.

The national poll showed 65 per cent in favor, 31 opposed and 4 undecided.

LIABILITY RATES UP IN 22 STATES; NOT MICHIGAN

Revisions in the basic limit rates for physicians and surgeons professional liability insurance in 22 states were announced today by the Insurance Rating Board on behalf of its member and subscriber companies. Michigan was not included.

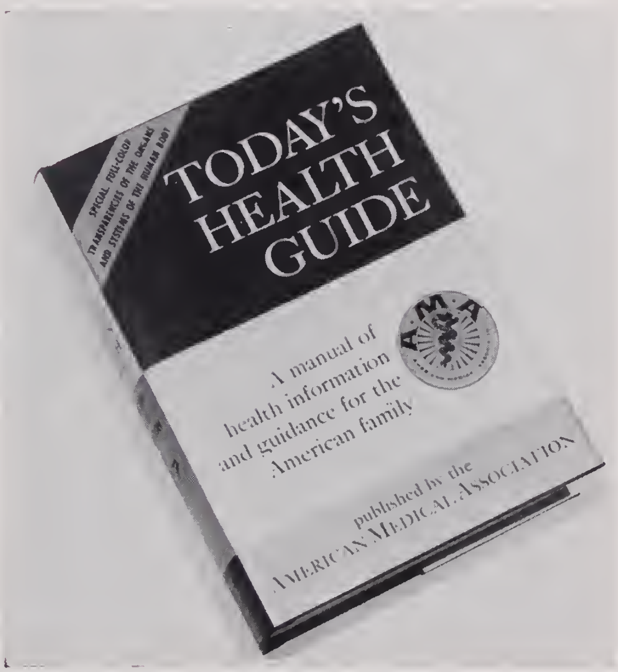
The revisions in basic limit rates result in increases in 21 states and a reduction in one. In the midwest, the Illinois rates went up 20 per cent; Indiana 30 per cent; Ohio 75 per cent. California rates went up 38.2 per cent.

Adverse underwriting experiences were cited as the reasons for the increases.

TEDDY SAID IT WELL

"In a republic like ours the governing class is composed of the strong men who take the trouble to do the work of government, and if you are too timid or too fastidious or too careless to do your part in this work, then you forfeit your right to be considered one of the governing and you become one of the governed instead. . ."

Theodore Roosevelt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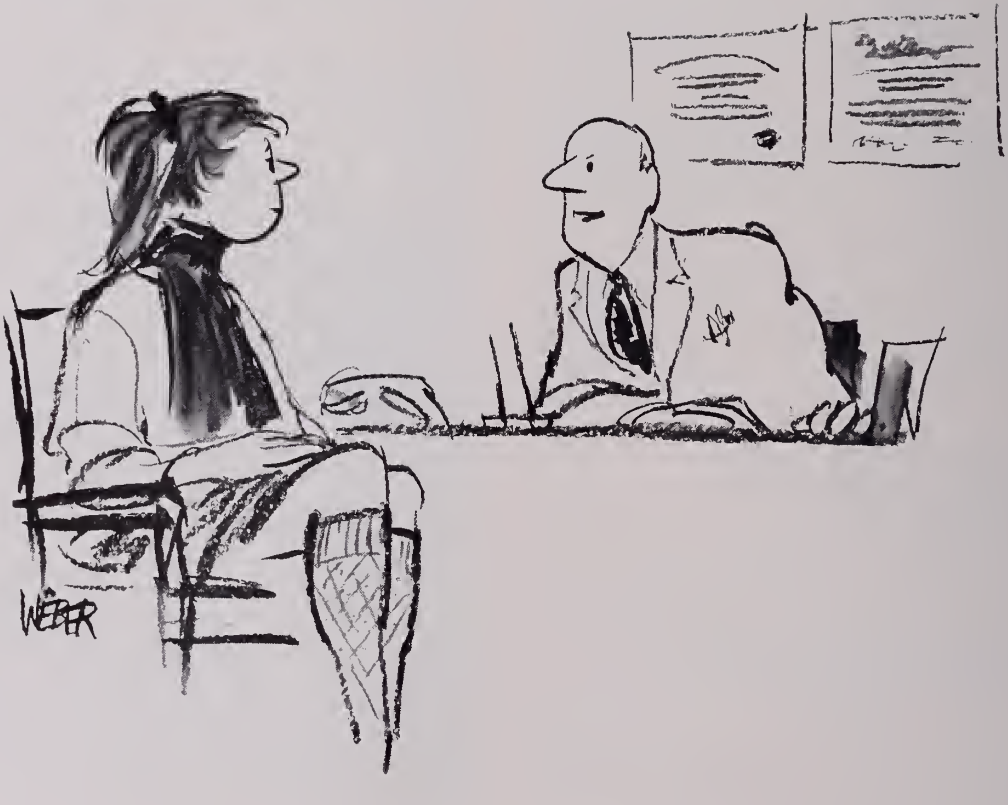
County medical societies are purchasing copies of the AMA Today's Health Guide book for presentation to libraries, schools and other community outlets. The book, which physicians might like to have available in their waiting rooms, contains 640 pages of general advice. Copies are available at cost from the AMA at $5.95. More than 20,000 diseases, illnesses, medical conditions and subjects are thoroughly covered, with more than 300 illustrations.



"Now that your acne is clearing up nicely, it might be a good idea if you started losing some weight."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.)
Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8

70 Medical Research Projects Supported by Michigan Heart Association

Michigan researchers are now working on 70 Michigan Heart Association supported studies. Total of the grants-in-aid is $551,039. Other expenditures, including $165,000 – 60% of all monies sent to the American Heart Association – brought MHA's total research support during the fiscal year beginning July 1 to about $800,000.

Michael C. Kozonis, M.D., Pontiac, president of the Association, says that, "By the end of this year, our 19th, MHA will have spent about $7,200,000 on research in Michigan." The funding came from the Michigan United Fund, supplemented by Memorial Gifts, money willed or given the Association in honor of a friend or relative, victim of heart disease.

Sixty-one of the projects are in the three Michigan medical schools; 31 at Wayne State; 23 at University of Michigan; and 7 at Michigan State. Three are at Henry Ford Hospital in Detroit, and one each at the Rehabilitation Institute, and Sinai, Providence, and Detroit Memorial Hospitals, all in the Detroit area, the University of Detroit, and Blodgett Memorial Hospital, Grand Rapids.

MHA also gives a total of $70,000 in supplemental funds to the deans of the three medical schools, and uses $17,500 to support the research of medical students. These are in addition to the grants-in-aid, which range from $2,500 to $12,000, and are used to hire technicians and buy supplies.

The researcher, their institutions, and the titles of their projects, follow:

WAYNE STATE UNIVERSITY

HANLEY ABRAMSON, Ph.D., College of Pharmacy, "Cardenolide Alkylating Agents as Potential Irreversible Inhibitors of Transport Adenosine Triphosphatase."

GORDON F. ANDERSON, Ph.D., Dept. of Physiology and Pharmacology, "Ultrastructural Changes and Metabolism of Warfarin Sodium."

AUGUSTIN ARBULU, M.D., Dept. of Surgery, "Myocardial Revascularization Using a Newly Created Arteriovenous Fistula."

MARION I. BARNHART, Ph.D., Dept. of Physiology and Pharmacology, "Leucocytic Function During Thrombosis."

RICHARD J. BING, M.D., Dept. of Medicine, "Myocardial Failure; Myocardial Contractility; Studies on the Capillary Circulation of the Heart."

CHARLES M. COWAN, M.D., Dept. of Medicine, "Measurement of Coronary Blood Flow Using Rubidium-84, A Positron Emitter."

DANICA DABICH, Ph.D., Dept. of Biochemistry, "Catabolism of Proteins."

MYRON K. DENNEY, M.D., Dept. of Surgery, "Venolymphatic Communications."

SIGMUNDUR GUDBJARNASON, Ph.D., Dept. of Medicine, "Energy and Lipid Metabolism of Infarcted Heart Muscle."

RAYMOND L. HENRY, Ph.D., Dept. of Physiology and Pharmacology, "In vivo Observations and in vitro Analysis of Experimental Thrombi."

TODD S. ING, M.D., Dept. of Medicine, "Determination of Intra-Renal Distribution of Blood Flow with Radioactive Xenon in Renovascular Hypertension."

A. MARTIN LERNER, M.D., Dept. of Medicine, "Studies of a Severe Murine Virus Myocarditis and Cardiomyopathy."

LAWRENCE LEVINE, Ph.D., Dept. of Biology, "Cytochemical Adenosine Triphosphatase; Loci of Elementary Mechano-chemical Transduction Sites."

EBERHARD F. MAMMEN, M.D., Dept. of Physiology and Pharmacology, "Blood Coagulation Changes Related to Shock."

D.S. McCANN, Ph.D., Dept. of Chemistry, "Role of Elastin in Experimental Atherosclerosis."

JOHN S. MEYER, M.D., Dept. of Neurology, "A New Method for Measuring Regional Cerebral Blood Flow in Man; Development of the Method in Monkeys."

ROBERT A. MITCHELL, Ph.D., Dept. of Biochemistry, "Pathways for ATP Synthesis and Utilization of Heart Muscle Mitochondria."

HIROSHI MIZUKAMI, Ph.D., Dept. of Biochemistry, "Studies of Hemoglobin from Cardiovascular Disease Patients."

CHARLES J. PARKER, JR., Ph.D., Dept. of Biochemistry, "A Study of the Mechanism of Relaxation in Heart Muscle."

LAWRENCE POWER, M.D., Dept. of Medicine, "Atherosclerosis and Carbohydrate Intolerance."

JEANNE M. RIDDLE, Ph.D., Dept. of Pathology, "Platelet Ultrastructure in Thrombotic Diseases."

JERRY C. ROSENBERG, M.D., Dept. of Surgery, "Effect of Various Resuscitative Measures on the Hemodynamic and Metabolic Changes Produced by Shock Secondary to Acute Massive Pulmonary Embolus."

VISHWANATH M. SARDESAI, Ph.D., Dept. of Surgery, "Myocardial Carbohydrate Metabolism in Endotoxin Shock."

IRWIN J. SCHATZ, M.D., Dept. of Medicine, "Study of Triglyceride and Fat Synthesis in Patients with

(Continued on 1403)

n the complex picture
f moderate to severe anxiety...

ere is a new reason
or prescribing Mellaril (Thioridazine HCl)

ffectiveness in
ixed anxiety-depression

ng recognized for its usefulness in the
eatment of moderate to severe anxiety,
ellaril is now also known to be effective
ainst mixed anxiety-depression.

ten the symptoms of anxiety states are
ficult to sort out—even with the most careful
obing. The patient may manifest symptoms of
itation, restlessness, insomnia, somatic
mplaints. But what of the depression that may
mixed in the total picture? It is reassuring
know that Mellaril may be prescribed—with
rong possibilities of success—when there is
xiety alone or a mixture of anxiety
d depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170

Louie!
You're
back.

Louie lost weeks with acute shoulder bursitis. That's a
of pain, stiffness and tenderness...and also a lot of f
It might have been different with **Butazolidin® al**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forge

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka **Geigy**

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

The Divorced Depressive: "Forty Forgotten

"Had a large wedding."
"Had a fine home and family."

.Forlorn”

d a divorce.”
a real loser,
d so are
kids.”

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.[1]

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

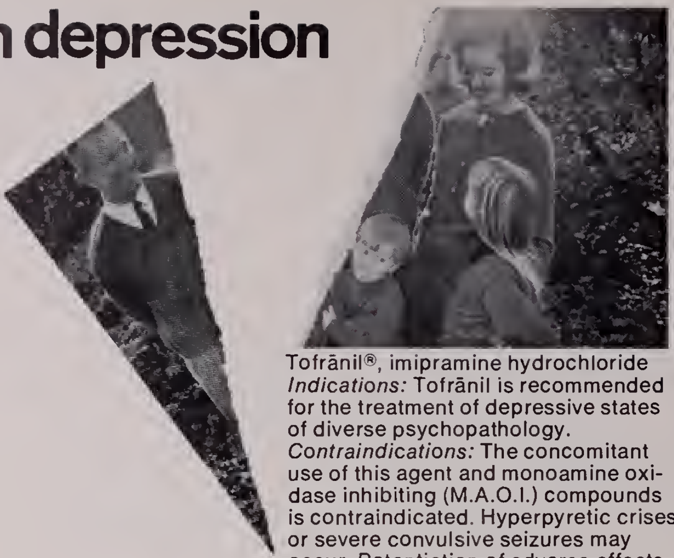
Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

in depression **Tofrānil®** imipramine hydrochloride

Geigy

in depression



Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.

In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at the present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).

Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

et's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Campbell's
CONDENSED
SOUP

In childhood

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pup s, tachycardia; continuous observation is necessary

Adverse Reactions: Side effects reported w Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages given in divided doses until diarrhea is controlled, are as follows:

diarrheas...

- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride (Warning: May be habit forming)	2.5 mg.
atropine sulfate	0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

hildren: Total Daily Dosage

3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
dults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

ased on 4 cc. per teaspoonful.

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s one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. **2.** Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. **3.** Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. **4.** Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

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and *reducing diets*

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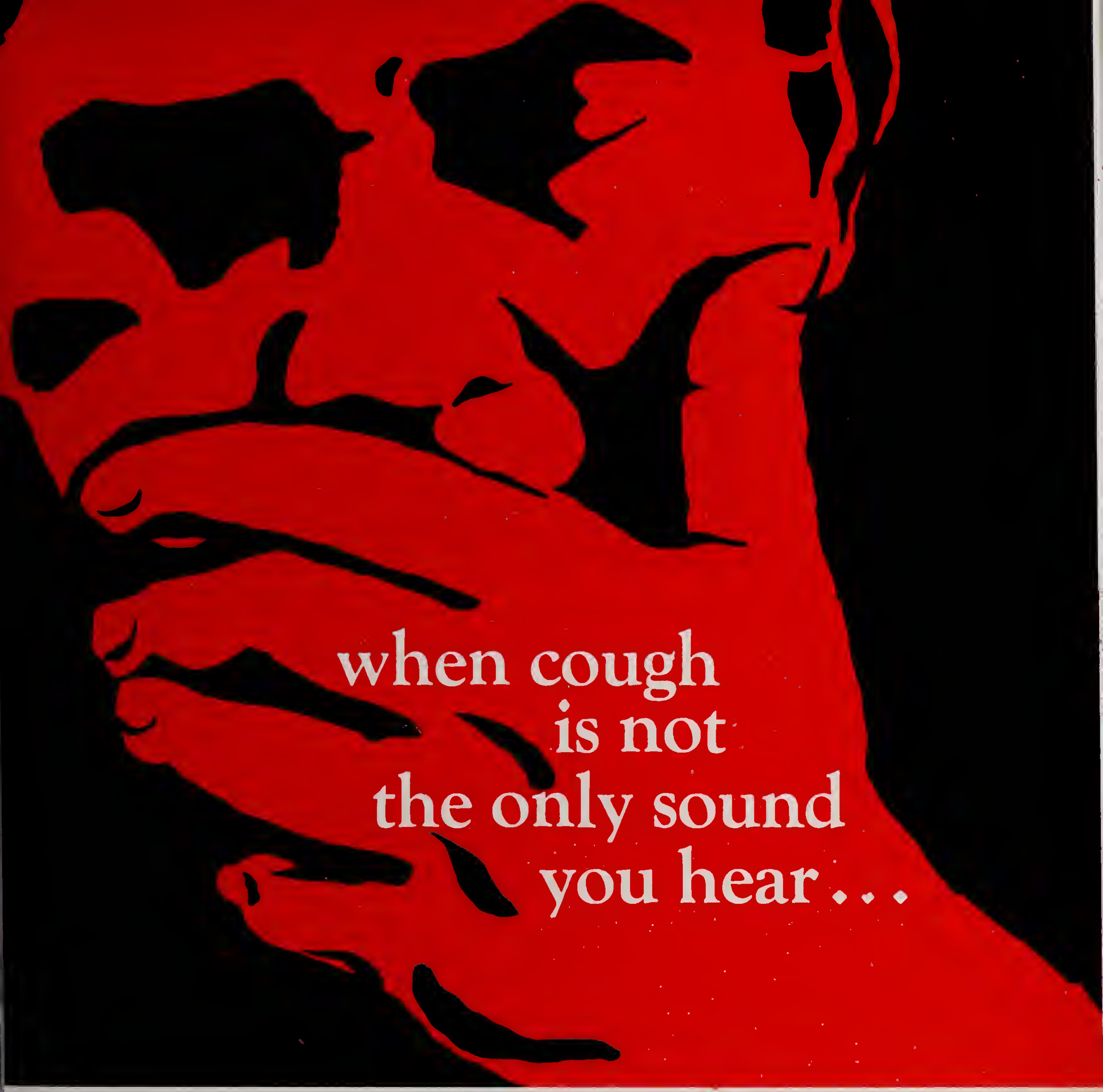

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Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

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Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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327-8

Various Types of Hyperlipidemia and their Inter-relationships with Glucose Metabolism."

ROBERT S. SHEPARD, Ph.D., Dept. of Physiology and Pharmacology, "Changes in Cardiac Performance in the Conscious Dog in Response to Automatic Agents, Pacing, Exercise, and Anesthesia."

ALLEN SILBERGLEIT, M.D., Dept. of Physiology and Pharmacology, "An Experimental and Clinical Study of Platelet Aggregation in Man and the Relationship to Thrombosis."

CALVIN L. STEVENS, Ph.D., Dept. of Chemistry, "Synthesis of Aminosugar Cardiac Glycosides."

DEMETRIOS C. TRIANTAPHYLLOPOULOS, M.D., Dept. of Physiology and Pharmacology, "Studies on Lysed Fibrinogen."

ALEXANDER J. WALT, M.D., Dept. of Surgery, "Massive Blood Transfusion; A Prospective Study of the Associated Biochemical Hemodynamic and Coagulation Changes."

ROBERT F. WILSON, M.D., Dept. of Surgery, "Cardiovascular Changes in Shock and Trauma."

BENNIE ZAK, Ph.D., Dept. of Pathology, "Soluble Adenines, Nucleic Acids, Nucleic Acid Nucleotides and Base Pair Ratios, Enzymes, Total and Soluble Proteins, Lipid Levels and Trace Metals of Heart Muscle."

UNIVERSITY OF MICHIGAN

WALTER M. BAIRD, M.D., Dept. of Pharmacology, "An Investigation of the Pharmacodynamic Effects of Cardiac Antiarrhythmic Agents in the Intact Animal by Radioisotopic Tracer Techniques."

JOHN G. BATSAKIS, M.D., Dept. of Pathology, (A) "Iatrogenic Aberrations of Serum Enzyme Activity and Methodological Assessment of LDH Isoenzyme Techniques." (B) "Serum Lipoproteins, Their Electrophoretic and Thermal Characteristics."

LLOYD BECK, Ph.D., Dept. of Pharmacology, "Humoral Control of the Capacitance System: The Nature and Neurosecretory Control of the Renal Agent Involved."

GERALD L. BRODY, M.D., "To Determine What Proportion of Ischemic Myocardium Undergoes Necrosis in Myocardial Infarction."

JAMES CONWAY, M.D., Ph.D., Dept. of Internal Medicine, "Hemodynamic Changes in Experimental Hypertension."

WILLIAM W. COON, M.D., Dept. of Surgery, "Effect of Low Molecular Weight Dextran Upon Plasma Clearance and Tissue Distribution of C14-Cholesterol."

SUNIL K. DAS, M.D., Dept. of Internal Medicine, "Studies of Anti-heart Immunoglobulins in Patients with Cardiomyopathy and Similar Studies in Relatives of Patients with Cardiomyopathy."

JOHN R. P. FRENCH, JR., Ph.D., Institute for Social Research, "Work Overload and Risk Factors in Coronary Heart Disease."

JAMES A. GREEN, JR., M.D., Dept. of Internal Medicine, "Cardiovascular Hemodynamics in Experimental Nephritis."

SIBLEY W. HOOBER, M.D., Dept. of Internal Medicine, "Management of Hyperlipidemia in Ambulatory Patients."

DONALD R. KAHN, M.D., Dept. of Surgery, "Late Results of Open Heart Operations."

BENEDICT R. LUCCHESI, Ph.D., Dept. of Pharmacology, "Effects of Insulin Upon the Normal and Digitalized Heart."

JOE D. MORRIS, M.D., Dept. of Surgery, "Surgical Treatment of Acquired Heart Disease Including Myocardial Revascularization by Means of Direct Myocardial Perfusion With Left Ventricular Blood."

JOHN A. PENNER, M.D., Dept. of Internal Medicine, "Mechanisms of Blood Coagulation."

ERNEST W. REYNOLDS, JR., M.D., Dept. of Internal Medicine, "Evaluation of Propranolol and Quinidine in the Treatment of Quinidine Resistant Arrhythmias, Studies by Continuous Monitoring."

HERBERT SLOAN, M.D., Dept. of Surgery, "Pulmonary Function Changes in Infants with Congenital Heart Disease Undergoing Surgical Repair."

JAMES A. TAREN, M.D., Dept. of Neurosurgery, "Magnetic Obliteration of Cerebral Aneurysms."

SATHAPORN VATHAYANON, M.D., Dept. of Surgery, "Cardiac Homotransplantation: Studies of Growth in the Homograft and of the Rejection Phenomenon in Young Calves."

PAUL A. WEINHOLD, Ph.D., Depts. of Biological Chemistry and Internal Medicine, "Inhibitions of Tyrosine Hydroxylase and Norepinephrine Biosynthesis."

JOHN M. WELLER, M.D., Dept. of Internal Medicine, "Study of Antihypertensive Agents."

PARK W. WILLIS, III, M.D., Dept. of Internal Medicine, "Epidemiology and Therapy of Occlusive Vascular and Thromboembolic Disease."

WEN-JEI YANG, Ph.D., College of Engineering, "Dynamic of Gas Emboli in Cardiovascular Systems."

ANDREW ZWEIFLER, M.D., Dept. of Internal Medicine, "Experimental Thrombosis."

MICHIGAN STATE UNIVERSITY

THEODORE M. BRODY, Ph.D., Dept. of Pharmacology, "Catecholamine-Thyroid Hormone Interaction in the Rat Heart."

REXFORD E. CARROW, Ph.D., Dept. of Anatomy,

(Continued on 1411)

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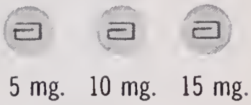

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Brief Summary

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DESBUTAL 15 Gradumet
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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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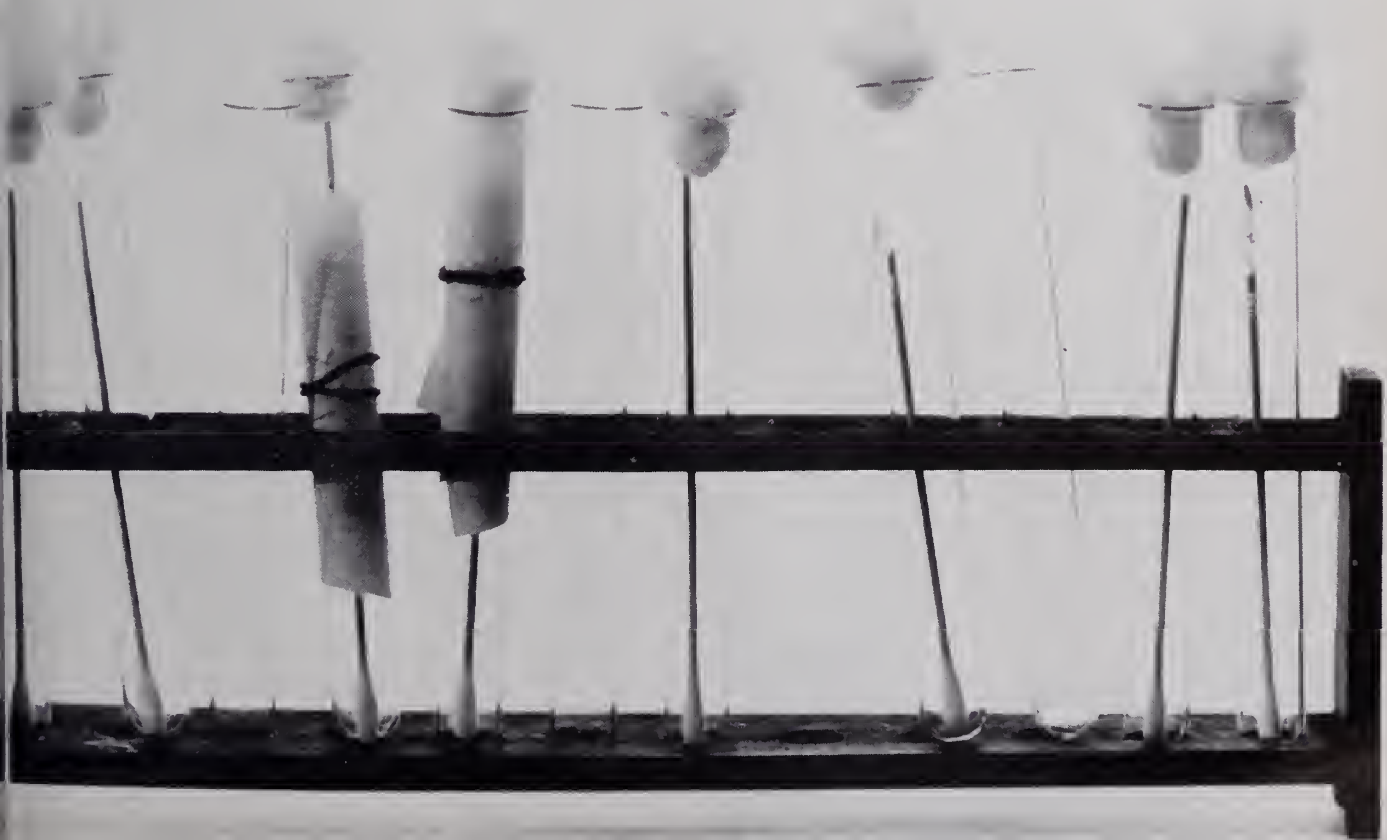

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In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

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RESEARCH PROJECTS/Continued

"Anatomy of the Sinus Node and Pulmonary Veins of Primates."

GEORGE E. EYSTER, V.M.D., Veterinary Clinic, "Studies of High Incidence Congenital Heart Disease in Inbred Cattle."

FRANCIS J. HADDY, M.D., Dept. of Physiology, "The Mechanism of Coronary Vasodilation Caused by Adrenergic Stimulation."

JERRY B. HOOK, Ph.D., Dept. of Pharmacology, "Effect of Several Saluretic-Diuretic Agents on Renal Na-K-Activated ATPase and Renal Hemodynamics."

HENRY W. OVERBECK, M.D., Depts. of Physiology and Medicine, "Vascular Responses in Experimental Hypertension."

OTHER PROJECTS

WILLIAM J. FERRELL, Ph.D., Dept. of Chemistry, University of Detroit, "Analysis of Human Cardiac Aldehydogenic Lipids."

ALBERTO MANZOR, M.D., Detroit Memorial Hospital, "Internal Revascularization of the Left Ventricle."

WALTER D. MEESTER, M.D., Ph.D., Blodgett Memorial Hospital, Grand Rapids, (A) "The Effect of Epinephrine on Lipid Metabolism." (B) "Pharmacological Evaluation of Various Drugs Blocking the positive Inotropic Action of Epinephrine."

ROBERT E. MOSHER, Ph.D., Providence Hospital, Southfield, "The Quantitative Distribution of Copper in Normal and Diseased Human Myocardial Tissue."

FRANCES E. NOE, M.D., Sinai Hospital, Detroit, "Measurement of Effective Pulmonary Blood Flow and Its Correlation with Blood Buffer Capacity in Normal Subjects and in Patients with Acquired and Congenital Heart Disease."

JAN NYBOER, M.D., D.Sc., Rehabilitation Institute, Detroit, "Evaluation of Ballistocardiography and Electrical Impedance Plethysmography."

JOSEPH D. SHORE, Ph.D., Henry Ford Hospital, "The Mechanisms of Regulation of Heart Mitochondrial Malate Dehydrogenase."

D. EMERICK SZILAGYI, M.D., Henry Ford Hospital, "An Investigation of the Use of Vascular Substitutes in the Replacement of Arterial Segments."

FRED W. WHITEHOUSE, M.D., Henry Ford Hospital, "Study of Aberration of Carbohydrate and Fat Metabolism in Various Types of Hyperlipidemia."

INTERESTING READING:

Many of the bookstores are selling a pocketbook version of "Understanding Media" by Marshall McLuhan. The highly-respected, popular author discusses two fundamental questions about the modern world: What are communications and how do communications affect mankind? The work interprets the entire process of communications from the invention of movable type through the electronic age.

PROCTOLOGY IN ANCIENT EGYPT

Since physicians are men of learning, knowledge of medical history is a necessity, not a luxury. In the absence of a history of proctology, this essay hopefully provides some insight into the management of anorectal disorders mentioned in the medical papyri.

Testifying to the quality of medicine practiced and recognizing the antiquity of the specialty of proctology, some of the knowledge passed along from ancient Egypt continues to influence present-day medicine. Enemas and suppositories are still in fashion. To unload their colons, people continue to take fruit, senna, colocynth and castor oil. The ancient Egyptians treated diarrhea, round and tapeworm infestations and bilharziasis; the medical specialists who treated anorectal disorders were held in especial esteem.

All these little known historical facts of our medical heritage should be bettter publicized to promote respect for the antiquity of our profession, to inspire a greater appreciation of this legacy from the past, and to provide moderation in evaluating our progress. — Leon Banov, Jr., M.D., Charleston, South Carolina: *Southern Medical Journal.*

Anatomy courses at colleges in Michigan and the nation are a far cry today from the lectures of 75 years ago. This photo, from the historic collection of the University of Michigan Medical School, shows five medical students: left to right, Edwin A. Murbach, Stephen C. Glidden, Howard A. Herrington, and James F. Breakey, all in the Class of 1894, and Laurence C. Grosh, right foreground, Class of 1895.

IN MEMORIAM

J. G. Bayles, M.D., Detroit

John G. Bayles, M.D., Detroit general practitioner for 40 years, died September 20. He was 67.

Doctor Bayles received his premedical education at the University of Michigan. He was graduated from the Tulane Medical School of Louisiana in 1929. His hospital affiliation was with Lincoln Hospital.

He was a 32nd degree Mason and a member of Phi Lambda Kappa medical fraternity.

M. J. Budge, M.D., Alma

Melvin J. Budge, M.D., Alma general practitioner, died September 16 at the age of 79.

A Life Member of MSMS, he had practiced in Ithaca since 1921. He also was an anesthesialogist at Gratiot Community Hospital, Alma, from 1959 until his retirement in 1966.

Doctor Budge was graduated from the University of Michigan Medical School in 1920. Previously a teacher, he served as principal of Riverdale Schools from 1910-12, as principal of McAllen School, McAllen, Texas, from 1913-14, and as superintendent of schools at Coleman, Michigan, 1914-15. During World War I he was a member of the Medical Corps.

He served on the Ithaca School Board and was a member of the American Society of Anesthesiologists.

J. S. Burleson, M.D., Grand Rapids

John S. Burleson, M.D., Grand Rapids, a former vice president of the American Proctological Society, died September 25. He was 58. Doctor Burleson was the owner and director of Burleson Hospital in Grand Rapids for 31 years.

He was graduated from the Medical College of Virginia in 1937. After serving his internship at Butterworth Hospital, Grand Rapids, he entered practice in Grand Rapids. In 1943 he served as chief proctologist at the Detroit House of Corrections.

He was a Fellow of the International Academy of Proctology and a member of the American Proctological Society, the American College of Surgeons, and Alpha Kappa Kappa.

H. Q. Groos, M.D., Escanaba

Harold Q. Groos, M.D., Escanaba physician for about 40 years, died at the age of 69.

Doctor Groos, a native of Escanaba, had been in practice there since 1928. He was a 1924 graduate of the University of Illinois Medical School.

In the past he had served as president, vice president, secretary and treasurer of the Delta-Schoolcraft County Medical Society.

He was surgeon for the Chicago & North Western Railroad and was also associated with the Harnischfeger Corporation. He was affiliated with St. Francis Hospital, Escanaba.

Doctor Groos was a member of the American Association of Railway Surgeons, Michigan Industrial Medical Association and Nu Sigma Nu.

E. L. Hansen, M.D., Battle Creek

Edwin L. Hansen, M.D., Battle Creek surgeon and gynecologist for many years, died September 29. He was 67.

Doctor Hansen was graduated in 1924 by the Loma Linda University School of Medicine in California. His internship was served at the Los Angeles General Hospital. He did postgraduate work in hospitals in Denmark, Germany and Austria.

He was a Fellow of the American College of Surgeons and a member of the Pan-Pacific Surgical Society and of numerous fraternal orders.

Doctor Hansen was the brother of Harvey C. Hansen, M.D., also of Battle Creek.

D. R. Hagge, M.D., Livonia

Donald R. Hagge, M.D., chief of surgery at St. Mary Hospital in Livonia, died September 13 at the age of 46.

Doctor Hagge was immediate past president of the Michigan Archaeological Society. Particularly interested in disease in prehistoric man, he was the author of a book on paleopathology.

He received the M.D. degree from the State University of Iowa in 1945. From 1946 through 1948 he served as a flight surgeon in the Medical Corps.

Formerly chief of staff at St. Mary Hospital, he was also affiliated with Harper and Mt. Carmel hospitals in Detroit and William Beaumont Hospital in Royal Oak.

Doctor Hagge was a Fellow of the American College of Surgeons and a member of the Detroit Surgical Society, Detroit Surgical Association, and Phi Rho Sigma fraternity.

Robert Licht, M.D., Detroit

Robert Licht, M.D., a radiologist at Mt. Carmel Mercy Hospital, Detroit, died September 26. He was 42.

(Continued on 1417)

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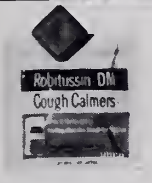
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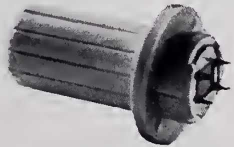

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GENERAL PRACTITIONER, INTERNIST, ORTHOPEDIST, OB-GYN needed for additional staff to establish 15-man medical group in Detroit. Excellent professional relationships together with financial opportunities. Reply Box 19, 120 West Saginaw Street, East Lansing, Michigan 48823.

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Doctor Licht was graduated in 1954 from the University of Michigan Medical School. From 1958 to 1960 he served in the Navy Medical Corps.

He was a diplomate of the American Board of Radiology and a member of the American College of Radiology.

J. W. MacKenzie, M.D., Grosse Pointe

John W. MacKenzie, M.D., a former chief of staff of Cottage Hospital, Grosse Pointe, died September 21. He was 75.

Doctor MacKenzie was born in Toronto, Canada, and was graduated from the Toronto Medical School in 1917. From 1917 to 1919 he served in the Canadian Medical Corps.

He began practice in Grosse Pointe in 1922.

He was a Life Member of MSMS and a member of Alpha Kappa Kappa medical fraternity.

E. W. Secord, M.D., Detroit

Eugene W. Secord, M.D., Detroit, a past president of the Detroit Academy of Orthopaedic Surgeons, died August 30. He was 65.

Doctor Secord received B. S. and M. S. degrees from the University of Detroit and he was graduated from the Yale University School of Medicine in 1932. His internship was at University Hospitals, Cleveland, Ohio. He was a fellow in orthopedic surgery at Mayo Clinic for three years and he remained on the Mayo Clinic staff for two years. He earned the M.S. degree in orthopedic surgery from the University of Minnesota.

Shortly after he began practice in Detroit in 1938, he organized the orthopaedic section at Mt. Carmel Hospital. He was also in charge of the outpatient department at Veterans Hospital.

Doctor Secord was a member of the Detroit Surgical Society, Association of Bone and Joint Surgeons, American Academy of Orthopedic Surgery, Clinical Orthopedic Society, Crippled Children Society. He was also a member of Alpha Kappa Kappa and Sigma Xi.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

H. David Fenske, M.D., South Haven, has been presented the Medical Merit of Honor, South Vietnam's highest civilian award, by the South Vietnamese Ministry of Health for his efforts in establishing a national eye-care program. In addition to his duties as 12th USAF Hospital Chief of Ophthalmology and ophthalmology consultant for the Pacific area, Doctor Fenske has been active in the development of the Cam Ranh City Orphanage and also in the Med-Cap civilian aid program, a voluntary medical mission.

Arthur W. Strom, M.D., Hillsdale, was installed as president of the Michigan Society of Internal Medicine at the annual convention at Hidden Valley. He had served as a director of the society for some time.

V. A. Marks, M.D., Midland, was the guest speaker at a recent meeting of the Midland Hospital Auxiliary.

James J. Lightbody, M.D., Detroit, MSMS President and medical director of the Michigan Chapter of the Arthritis Foundation, was a featured speaker at a free Arthritis Forum in Battle Creek. Vance B. Lancaster, M.D., Battle Creek, was coordinator of the forum, co-sponsored by the Michigan Chapter of the Arthritis Foundation and the Calhoun County Medical Society.

Henry E. Malcolm, M.D., Lansing, has returned to Lansing to practice gynecology after a year of practice in Freeport, Grand Bahama, Bahama Islands.

Stanley Moleski, M.D., Grand Rapids, has announced his retirement from the office of city physician of Grand Rapids which he has occupied for 23 years.

Lambert J. Geerlings, M.D., Fremont, was honored by Gerber Memorial Hospital with the presentation of a bronze plaque. The inscription praised him for his long service to that institution and for his dedication to the health care of the people in the community, "a source of inspiration to all those who labored with him."

William M. Chavis, M.D., Detroit, presented a paper before the Liberian Medical Association in Monrovia, Liberia, West Africa, on "The Significance of the Papanicolaou Smear as a Screening Technique for Cancer of the Cervix in a Private Black American Medical Practice."

William Dito, M.D., Pontiac, conducted a seminar at Oakland University on "Chromosome Abnormalities," the opening session in a series of seminars developed for medical technologists.

Reuven Bar-Levav, M.D., Detroit, is the 1968-69 president of the Wolverine State Group Phychotherapy Society, an affiliate Society of the American Group Psychotherapy Association.

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

VOLUME 67, NUMBER 22 — NOVEMBER 1968 — DEADLINE FOR COPY NOVEMBER 21, 1968

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MICHIGAN MEDICINE

SEE LETTER TO STATE BOARD ON NEXT PAGE

MSMS Council Spells Out Immediate and Long-Range Recommendations to Educate More Physicians in State

Specific, detailed proposals to meet the present critical shortage of physicians in Michigan and to offer long-range solutions were outlined Nov. 6 by the Michigan State Medical Society Council in a letter to the State Board of Education.

The letter to Ira Polley, State Superintendent of Public Instruction, from Ross V. Taylor, M.D., Jackson, Council Chairman, stressed "deep concern about the serious shortage of physicians and paramedical personnel in Michigan."

MSMS REAFFIRMED PREVIOUS recommendations that the immediate medical manpower shortage can best be solved if sufficient funds are provided to expand the Michigan State University College of Human Medicine to a four-year, degree-granting medical school and to increase both the University of Michigan and Wayne State University medical schools to optimum size. MSU began a two-year medical school in 1966 and now has 78 students.

The MSMS Council, in the letter from Doctor Taylor, also offered several long-range solutions. MSMS urged the State Board of Education "to proceed with planning for an eventual fourth and fifth medical schools."

The Council spelled out that the Board should require that "each new medical school have affiliation with, and control by, a university possessing facilities for the education of ancillary and paramedical personnel."

IN A BOLD NEW APPROACH toward resolving the medical manpower shortage, the MSMS Council took unprecedented action in supporting the State Board of Education in its efforts to encourage the three medical schools "to take the necessary steps to develop curricula which will make possible the granting of either the degree of doctor of medicine or doctor of osteopathy according to the student's option." The MSMS letter also urged, "That each new school be developed so as to offer its students an educational program granting either the M.D. or D.O. degree upon graduation."

The State Board of Education officials have discussed the proposed degree option with officials of the three universities — University of Michigan, Wayne State University and Michigan State University — and also the administrators of the three medical schools. The three medical schools reportedly are considering possible options in degrees and curricula.

THE MSMS DEGREE OPTION recommendation follows the vote by its 1967 House of Delegates to admit qualified osteopaths to associate membership and is in line with the vote of medical doctors in a poll conducted in 1966 by the Michigan House of

(Continued on Next Page)

New MSMS Efforts to Obtain More Doctors Pick Up Momentum, Much Civic Support

The MSMS medical manpower efforts received strong support for businessmen, civic leaders, industrialists, labor officials, educators, professional men, hospital administrators, and others at the Battle Creek Conference on Michigan Medical Manpower October 23, the Grand Rapids regional conference November 14 and the Saginaw regional conference November 21.

RECOMMENDATIONS/Cont

Representatives State Affairs Committee, which asked all physicians, "Do you believe amalgamation of MDs and DOs would be in the best interest of the people of Michigan?" The Committee reported that an overwhelming majority of the doctors of medicine favored amalgamation, whereas osteopaths opposed it at that time.

The recommendations of the Medical Society Council bear a similarity to those accepted by the State Board of Education at its October 29 meeting from its Citizens Committee on Education for Health Care as ways to help solve the growing shortages of physicians and paramedical personnel.

THE DEGREE-OPTION PROPOSAL received the support November 11 of Dwight L. Wilbur, AMA president, in an address before the medical staff of Bon Secours Hospital in suburban Grosse Pointe. "The MSMS Council is to be complimented for its several proposals made to the State Board of Education to help relieve the medical manpower shortage in Michigan."

"The suggestion by MSMS that students be offered the degree option has definite economic advantages for taxpayers and also meets in a practical way any desire by some students to obtain an osteopathic degree," the AMA president declared. "That alternative would cost far less than to build any new college that would train only osteopaths, he suggested. Doctor Wilbur said many experts estimate the total cost to establish a completely new medical school is about $500,000 per student.

Doctor Wilbur explained that he was reacting to the Michigan State Medical Society's degree-option proposal as an individual. He pointed out that AMA has urged that osteopathic students should be given credit for courses whenever they transfer to MD schools. He reported that no MD college today offers the osteopathic degree.

MSMS LETTER TO STATE BOARD

November 8, 1968
The Honorable Ira Polley
State Superintendent of Public Instruction
520 Michigan National Tower
Lansing, Michigan 48933

Dear Doctor Polley:

The Michigan State Medical Society continues to be deeply concerned about the serious shortage of physicians within the state. The MSMS has for years been conscious of the expanding health needs in the State of Michigan. The manpower shortage of health personnel is becoming increasingly acute and is especially crucial regarding physicians.

For years the MSMS House of Delegates has urged continuous expansion of the state's medical schools and has acclaimed each step taken by the State Board in this direction. However, medical personnel shortages have continued to develop in spite of the Board's action, and will worsen unless the State Legislature provides the necessary funds to expand the Michigan State University medical school to a full degree program.

As part of the continuing study by MSMS of Michigan's responsibilities in the area of health needs, the recommendations of the "Citizens Committee of Education for Health Care" have been carefully reviewed. Immediate and long-range goals have been endorsed by The Council, meeting November 6, 1968. The Council of MSMS unanimously makes the following recommendations to the State Board of Education concerning immediate and long-range goals:

Immediate: Strongly reaffirm to the Governor of Michigan and the State Legislature its previous recommendation concerning the expansion to optimum size of the two existing degree-granting medical schools in Michigan; strongly recommend to the Governor of Michigan and the State Legislature that Michigan State University be provided sufficient funds to expand to a full degree-granting medical school of optimum size; encourage the medical schools at the University of Michigan, Wayne State University and Michigan State University (as an integral part of its expansion to a 4-year institution) to take the necessary steps to develop curricula which will make possible the granting of either the degree of Doctor of Medicine or Doctor of Osteopathy, according to the student's option.

Long-Range: Proceed with planning for an eventual fourth and fifth medical school for the State of Michigan, requiring that each new medical school have affiliation with, and control by, a university possessing facilities for the education of ancillary and paramedical personnel and that each new medical school be developed so as to offer its students an educational program granting either the MD or DO degree upon graduation.

The health needs of the people of the State of Michigan are of paramount importance and the patients' best interests must always be served. The MSMS believes that the foregoing recommendations will best meet the needs of Michigan and of the people. The origins of medicine or osteopathic medicine are of little importance with the continuing evolution of scientific medicine and the increasing quality of care. There is but one scientific basis of medical care and Michigan must continue to have medical schools of superior quality and pro-

MSMS Letter Continued:

ducing the highest caliber of physician. The degree option will permit the development of new schools of medicine with the science of medicine really determining the goals of medical education.

The MSMS therefore asks the State Board of Education to convene the authorities of the present medical schools so that studies may be initiated concerning the option of either the MD or the DO degree. If this is done, the schools all will be in a position to serve the young people of Michigan who wish to become either doctors of medicine or doctors of osteopathy. Such a course will offer that training in institutions of proven excellence and to the advantage of all of the people, and will make the most responsible and economical use of public funds.

Copies of this communication are enclosed for all members of the State Board of Education. Please be assured that the Michigan State Medical Society offers to the State Board and educational authorities of the medical schools its full cooperation in the implementation of these recommendations.

Very truly yours,
Ross V. Taylor, MD
Chairman of The Council

CC: The Honorable George Romney
Governor of Michigan
The Honorable Edwin L. Novak, President
State Board of Education

NEW DETROIT COMMITTEE ADDS DOCTOR BRUSH

Brock E. Brush, M.D., Detroit, is one of ten new members elected to the New Detroit Committee.

The organization, which recently incorporated under the name "New Detroit, Inc.," begins its second full year of operation. It was established following the 1967 Detroit riots, and seeks solutions to urban problems within the city, especially in areas of race relations. Members are elected on a rotating basis.

Careers Mobile In Detroit Area

Thousands of public health physicians and allied health professions viewed the Michigan Health Careers Mobile at Cobo Hall, November 11-15.

Then the Michigan Health Council Mobile moved to the WSU Careerland to tell WSU students more about the many career possibilities in the medical field.

The Mobile is scheduled for Highland Park Nov. 20-22.

Watch Next Issue for Desk Cards

The December issue of Michigan Medicine will include new copies of the "MSMS Maternal Health Desk Reference Cards #1 through #11" for all members to tear out and use.

The cards have been developed by the MSMS Committee on Maternal Health and have been issued periodically since 1961 to help MSMS members.

MSMS Judicial Commission Voting Underway

The deadline will be Dec. 1 for ballots for the MSMS Judicial Commission. Ballots were mailed Oct. 15 to members in the Judicial Commission Districts One, Two and Three.

MSMS members in District One, all of Wayne County will vote for two commissions from a group of four nominees, Eugene Freitas, M.D., Hugh M. Fuller, M.D., Floyd B. Levagood, M.D., and Donald N. Sweeney, Jr., M.D.

Nominees for District Two, all of Macomb, Oakland and St. Clair Counties, are Harold A. Furlong, M.D., Pontiac, and Harry E. Lichtwardt, M.D., Royal Oak. One will be elected.

MSMS members in Ingham, Livingston, Monroe, Shiawassee and Washtenaw counties will select one of three candidates in District Three. Nominated were Richard D. Coak, M.D., Tecumseh; R. Wallace Teed, M.D., Ann Arbor; and Franklin L. Troost, M.D., Holt.

The MSMS Constitution and Bylaws provide for the election of a Judicial Commission, which has general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline and professional conduct of members.

DOCTORS HELP SCHOOL WITH SEX EDUCATION

A pilot study for establishing a formal sex education program for the Ludington area was approved by the Ludington Board of Education. The study will be sponsored by the West Shore Mental Health Clinic, the Mason County Medical Society, the Department of Education, and the local district.

The need for more physicians and allied health professionals in Michigan was stressed at the MSMS-MHC-MAP Conference on Michigan Medical Manpower October 23 by many speakers, including, left to right, Robert Rice, M.D., Greenville; Lionel Swan, M.D., Detroit; MSMS President James J. Lightbody, M.D., and AMA Past-President Milford Rouse. More than 200 participated in the conference at the MEA Conference Lodge.

Thyroid Workshop Soon at WSU

Interested physicians are invited to attend the Eighth Annual Thyroid Workshop at the WSU Medical School, December 11.

Principal speakers will be Sidney Ingbar, M.D., about "Pharmacology of Iodine," and Joseph Matovinovic, M.D., about "History of Goiter."

BARNARD SPEAKS AT HOPE COLLEGE

Christian Barnard, M.D., who performed the first successful human heart transplant received an honorary Doctor of Science degree when he delivers an address at Hope College Nov. 23.

Ground Broken For New Shield Service Center

Work has started on the Michigan Blue Shield and Michigan Blue Cross $30 million, 22-story Service Center in downtown Detroit.

The Service Center will include a 22-story office tower, three-level computer and support facility of 183,000 square feet and a five-deck parking garage. The 11½-acre site is adjacent to the Chrysler Expressway.

Completion of the entire complex is scheduled for early 1971.

Galens Ready To Ring Bells To Help Kids

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MICHIGAN STATE MEDICAL SOCIETY VOLUME 67, NUMBER 24 DECEMBER 1968

AMONG THE IMPORTANT ARTICLES:

Clinical Pathological Conference
MAP — A Decade of Accomplishments
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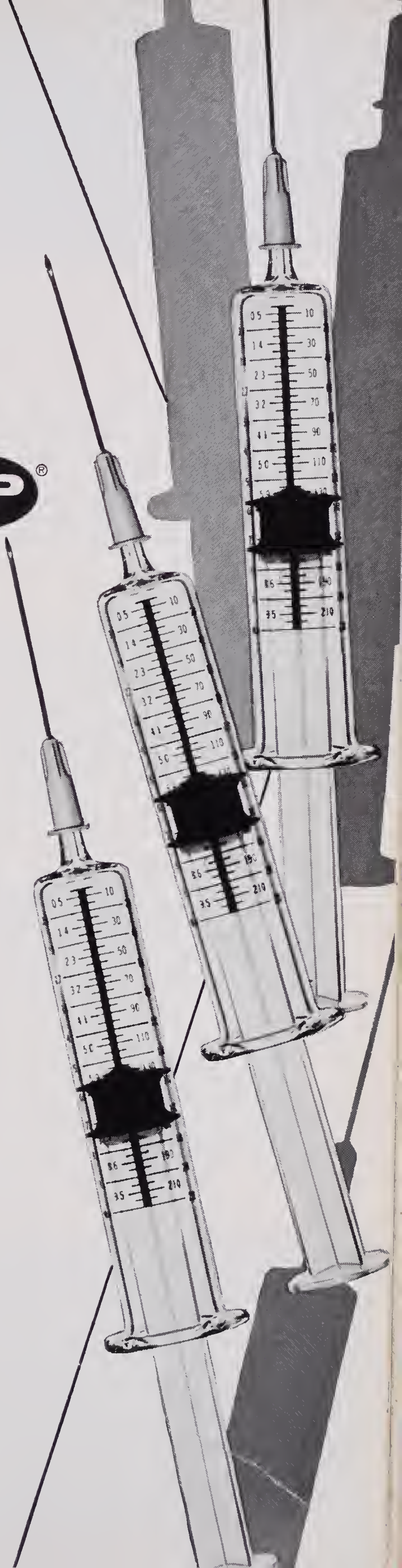

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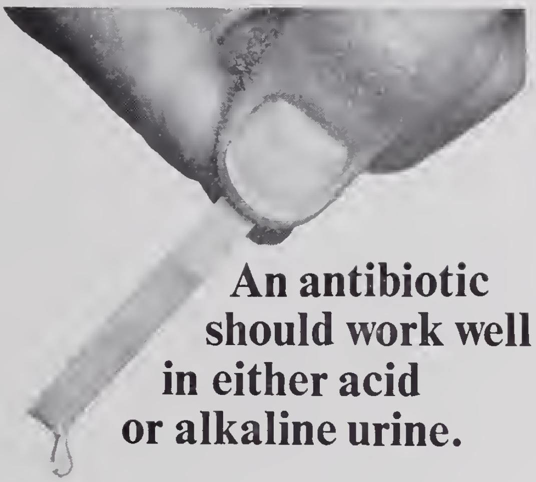

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BY JAMES J. LIGHTBODY, M.D.

MSMS PRESIDENT'S MESSAGE

For many years, we have had two political parties — they have been the Republican and the "Labor" Party. Labor unions have dominated the Democratic Party for too many years. The words "Liberal" and "Conservative" have been kicked around so much that we are more confused than usual about their real meaning.

Why should most of the large labor unions in this country persistently side-in with the Democrat Party and try to impress their large membership to vote Democratic in all important elections? It is obvious that the so-called "rank and file" members of unions have very little, if anything, to do with the political decisions and aspirations of their leaders. All that the union members are supposed to do is to pay their dues which are deducted from their regular paychecks and, with the assistance of the "checkoff" system, are automatically sent to the union headquarters.

The American Medical Association is not a political machine favoring either party and we can imagine what reaction the physicians of this country would have if the A.M.A. told them how to vote. It is generally agreed that the majority of physicians favor the more conservative approach to socio-economic problems of the country.

During the recent elections there was very little difference in the basic philosophy of the two main political parties as election time approached. Public opinion and expediency have much to do with the changing programs of both parties.

The recent election has proven that the Democrat Party, which traditionally was a predominant liberal philosophy, has changed its attitude because there seems to be a decreasing amount of federal funds available to pay for all of the programs sponsored by the Democratic administration. On the other hand — the Republican Party developed a semi-liberal attitude concerning some present programs and even suggested a few new ones to assist those groups of people who were economically, educationally and environmentally in the sub-standard classes.

We may eventually end up with a ten or fifteen party system that will add a little more confusion to the solitary confinement of our curtained voting booth. Anyway — ten or fifteen parties is too many — even during the Holiday Season.

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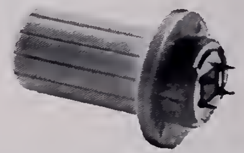

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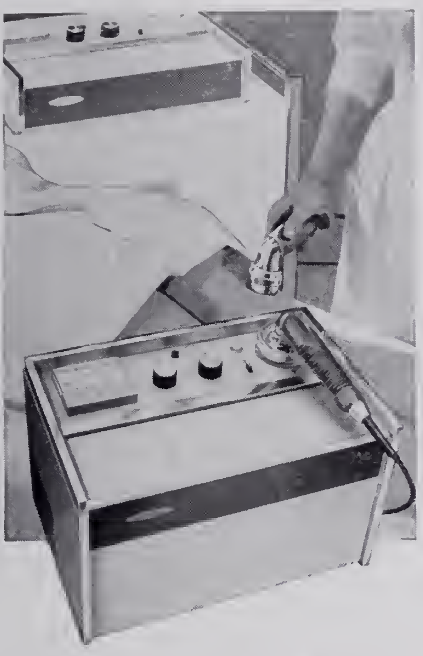

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Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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VIEWPOINTS

Welcome to Associate Scientific Editors

The MSMS Publication Committee is pleased to announce the formation of a board of Associate Scientific Editors. The names and addresses of the Associate Editors are listed in this and succeeding issues.

The Publication Committee has attempted to obtain Associate Editors representing geographic areas, speciality representation, medical school representation and clinical practice.

We are very happy to have such an excellent group representing *Michigan Medicine*.

Obesity Challenge

BY BROOKER L. MASTERS, M.D., CHAIRMAN
MSMS PUBLICATION COMMITTEE

As a physician are you doing the best job possible in handling obesity patients and in assuming leadership in the even broader field of nutrition?

"Middle-age obesity is said to be the major illness of our land today," writes C. F. Enloe, Jr., MD, in a recent issue of *Nutrition Today*.

Doctor Enloe then goes on to contend "that the practicing physicians' role in trying to get a firm grip on the obesity problem is less than enviable."

It seems to this observer that MSMS members and our Michigan research institutions do not focus proper attention on this common health problem and give it the attention it deserves. While we hesitate, the quacks and charlatans have moved into this field.

Doctor Enloe, in his article, "Are We Well Fed? Who Knows?," suggests several other related areas of concern. He suggests anything that can be done to improve the nutrition of the elderly is not only a moral obligation but economically wise.

We are not only concerned about nutrition of the elderly but also about the eating habits of children and young people. Often children and young people (who can afford good balanced meals) choose poor foods for their school lunch. We know that some children of the affluent often go to school with no breakfast or with a poor one. The nutritional status of our young people is so important; girls especially because they are becoming pregnant and giving birth at younger ages than a decade ago.

Physicians can and must work with dietitians and nutritionists to apply research to find out the facts; and then use our vast intellectual and physical resources to solve the nutritional problems that face too many children and adults, the elderly and poor in our communities, in Michigan, and the nation.

There Are No Short-cuts

(Editor's Note: This article appeared in a recent issue of the Genesee County Medical Society Bulletin; and was written by E. Marshall Goldberg, M.D., an associate editor.)

"It has been reliably estimated that only since the second decade of the twentieth century could a given patient consulting a given doctor reasonably hope to benefit from the encounter" . . . How things have changed!

The country doctor with his bag chock full of nostrums — most of which did little good, though, on the other hand, little harm — is a fond remembrance by many of us whose first interest in a career in medicine was kindled by the welcome sight of the venerable gentleman. He cured rarely, comforted always.

Nowadays, much more is expected. We have entered the era of a knowledge explosion. The turnover rate for new medical knowledge, 25 years in 1950, has now shrunk to five years — which, in effect, means that if any of us stopped reading and absorbing the contents of at least four medical journals a month for a five-year stretch, we would be a prime candidate for another tour of medical school.

WHY? THE PRINCIPAL reason, in my opinion, is that there are so few **totally incurable diseases anymore.** Each passing day in some medical journal published somewhere on this globe, a new mode of therapy may appear that removes one more disease process from the "certain death" category.

It is the physician's responsibility to keep up with these developments — to read *The New England Journal* as well as the *Wall Street Journal*

— and to assure such potential benefit reaches his patient sooner rather than later. It should not be inferred from this reference that only patients with rare diseases merit such diligence. One of the leading causes of hospital deaths is pulmonary emboli. New diagnostic techniques, such as lung scanning, have recently become available to permit early detection of this condition.

YET, HOW MANY physicians have made a concerted effort to familiarize themselves with both the subtle manifestations of pulmonary embolization and the usefulness and limitations of lung scans?

Multiple Myeloma, once a relentless process, has now yielded, in part, to combined therapy with such agents as cytoxan, sacrolysin, fluorides, androgens and cortisone. It remains a fatal disease, yet not totally incurable in the sense that several, reasonably comfortable years can be added to the patient's life by judicious management with these modalities.

Many state medical societies — most notably, Oregon's — have publicly recognized that a physician whose knowledge is out of date can be as much a hazard as a healer. His diagnostic acumen is the first to be tested by a patient suffering the ill-defined, early symptoms of a potentially serious disease.

IT IS NOT ENOUGH FOR him to know where he can refer the patient for "specialized" care. He must first make a tentative diagnosis; he must be truly skilled in the routine, often tedious, but indispensable art of doing a first-rate history and physical.

There are no short-cuts to this ritual; it is still at least 80 percent of the practice of good medicine. For the remainder, it is my opinion that the busy practitioner should avail himself more of the teaching program in his hospital; bend the program to fill his needs, correct the weak spots, as well as those of the fledgling house officer.

If he and a few of his colleagues feel they need a little brushing up in the latest techniques for, say, working up a patient with hypertension, he should make his feelings known to the educational director or the chief of the section rather than wait for a yearly conference on the subject.

He should be an ACTIVE rather than a passive — or worse, ABSENT — recipient of what his hospital has to offer him as a life-long student of medicine. It is unrealistic to expect to be able to catch up on all the medical advances that have been made in a year by attending a single refresher course. New knowledge, like good scotch, should be taken in small sips.

E. Marshall Goldberg, M.D.

Impotence

(Editor's Note: The following message appeared in a recent issue of the Oakland County Medical Society Bulletin.)

Once or twice a week some member of the Oakland County Medical Society stops me and asks "When is the county medical society going to ______________________?" The subjects in question run the gamut: community health, hospital politics, Medicare, Blue Cross-Blue Shield, Vietnam, etc. The answer is simple enough. Our county medical society is not an influential or potent organization and it is high time we stop having any illusions about our own importance as a political force.

Too many of our members contribute nothing to their county medical society. I can accept poor attendance at our monthly meetings as a fact of life but I cannot understand the lack of attendance at committee meetings. A year ago, I made an attempt to appoint people, including many new members, who expressed a willingness to work for the society as members of committees. Inexplicably most of our important committees are struggling along, their efforts hamstrung by less than 25 per cent participation by their members. As a case in point, several months ago our local schools asked for assistance in the area of student drug addiction. The responsible OCMS Committee met with only two of nine members present. No action was taken and the schools went elsewhere for help.

The cure for such impotence in any organization is the active and enthusiastic participation by its members.

Edwin J. Westfall, M.D.
President,
Oakland County
Medical Society

The Old Maid Still at the Keyhole

(Editor's Note: The following editorial by John S. Chapp Chaffee is reprinted from the May, 1968 issue of PENNSYLVANIA MEDICINE, published by the Pennsylvania Medical Society.)

Many years ago the renowned John B. Deaver received a phone call from one of his many referring G.P.'s. "John," said the referring doctor, "I've got an old spinster out here whom I believe has a gallstone colic. You should operate her, but they won't take my word for it. Now, if you were to come out here in consultation, you might persuade her to come to the hospital and get the operation over with."

The great Deaver went to the home accompanied by the doctor and with characteristic dignity examined the old maid. Then he asked to be excused so that he and the family doctor could discuss the case. They retired to the drawing room, closed the door and sat down. The family doctor handed Doctor Deaver a cigarette and they both lit up. After a pause, Doctor Deaver said, "Did you ever see such a homely old maid in your life?" To which the referring doctor replied, "If you think she is homely, wait until you see her sister."

At that moment, the door flew open. The enraged sister, who had been listening thru the keyhole, summarily ordered them both out of the house.

Perhaps physicians can hazard a lesson from this Philadelphia story.

A complacent medical profession irritated by the perplexities of public service, is over-confident because it is in short supply. The public, represented by the old maid, is observing us through the keyhole with a suspicious eye. It considers us a valued servant and tolerates great latitudes in our behavior. But if we are indiscreet in our professional obligations or disrespectful to our master, the public, we may awake to an enraged old lady who will toss us out or curtail our activities.

The old lady may be ever so homely, even unreasonable and we may not like her politics. Nevertheless, while being firm with her, we must patiently educate her and render her intelligent service. We must not insult her, for she is our master and we are her servants.

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DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
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PARKE-DAVIS 015R67

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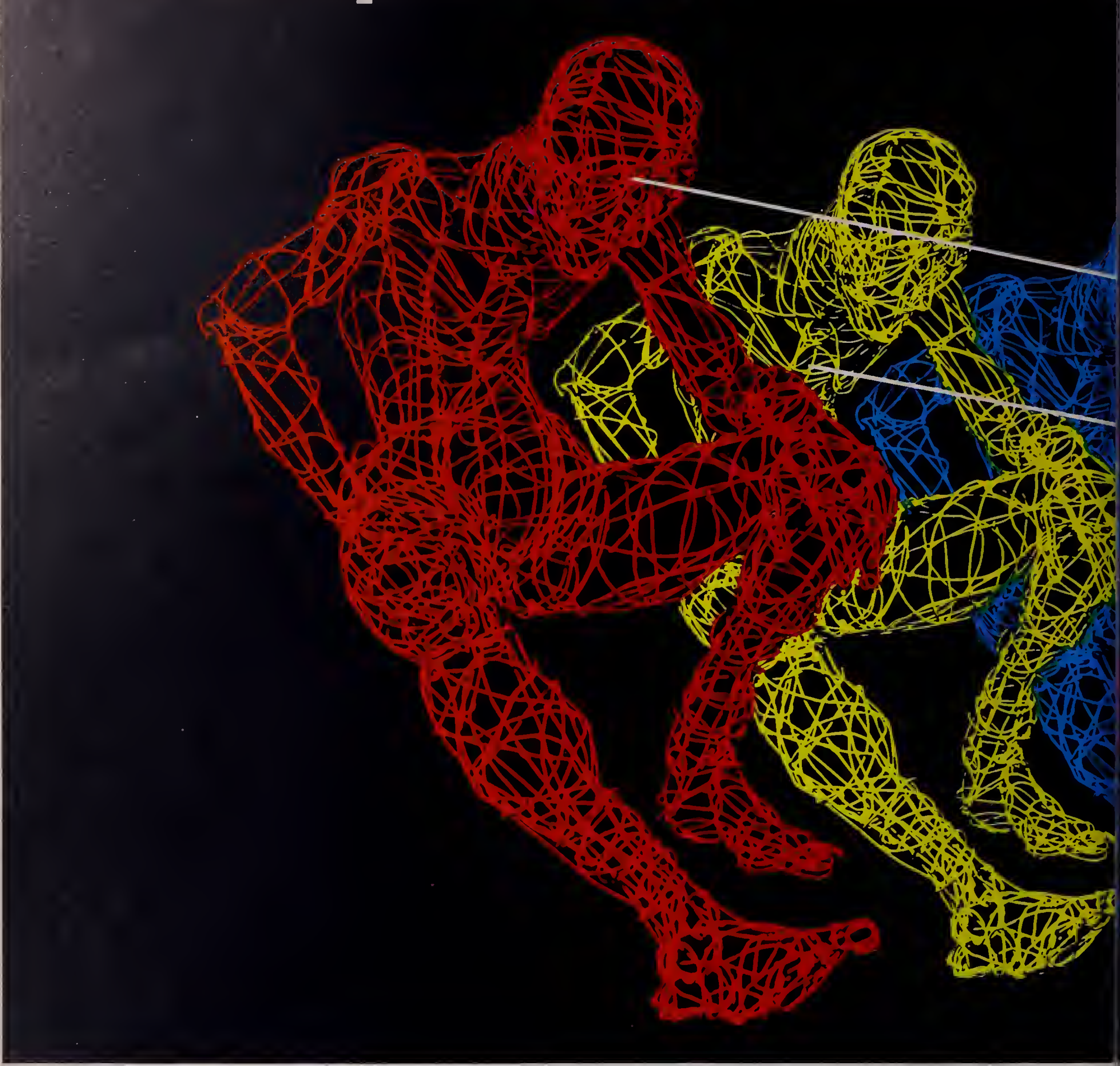

Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires approp
investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adeq
vitamin B_{12} therapy may result in hematologic remission but
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or oral with potent intrinsic factor as in Trinsicon® [hema
concentrate with intrinsic factor, Lilly]) usually prevent, hal
improve the neurological changes.

As with all preparations containing intrinsic factor, resist
may develop in some cases of pernicious anemia to the pote
tion of absorption of physiological doses of vitamin B_{12}. If re
ance occurs, parenteral therapy, or oral therapy with so-c
massive doses of vitamin B_{12}, may be necessary. No single
men fits all cases, and the status of the patient observe
follow-up is the final criterion for adequacy of therapy. Peri

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Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

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ical and laboratory studies are considered essential and are ommended.

erse Reactions: In rare instances, iron in therapeutic doses duces gastro-intestinal reactions, such as diarrhea or constiion. Reducing the dose and administering it with meals will imize these effects.

extremely rare instances, skin rash suggesting allergy has owed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after l administration of folic acid.

age: One Pulvule twice a day. (Two Pulvules daily produce a ndard response in the average uncomplicated case of pernius anemia.)

Supplied: Pulvules Trinsicon® (hematinic concentrate with insic factor, Lilly), in bottles of 60 and 500. [032568]

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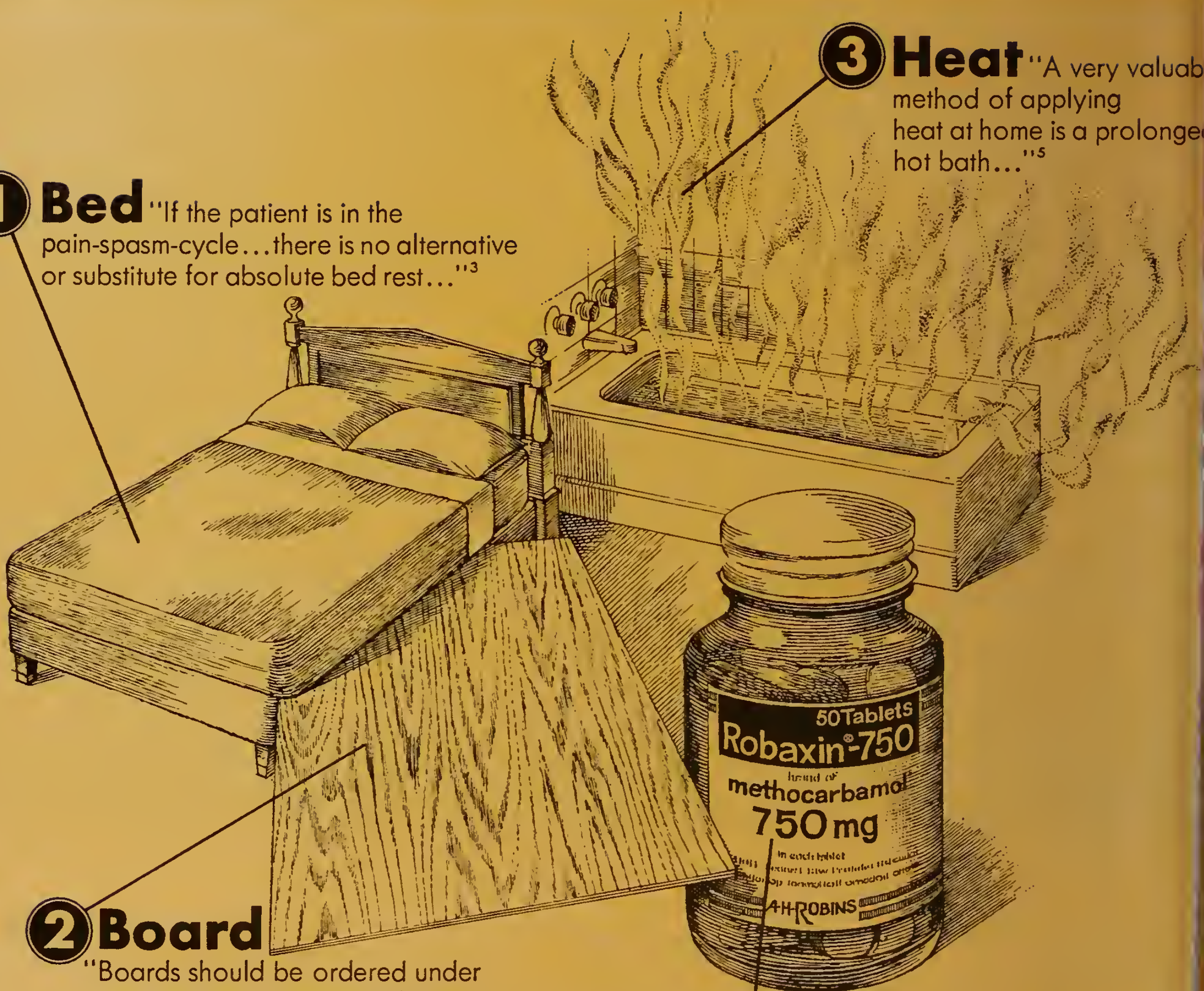
A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



① **Bed** "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

② **Board** "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

③ **Heat** "A very valuab method of applying heat at home is a prolonge hot bath..."[5]

④ **Robaxin®-750** (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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n the complex picture
f moderate to severe anxiety...

ere is a new reason
r prescribing Mellaril
(Thioridazine HCl)

fectiveness in
ixed anxiety-depression

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atment of moderate to severe anxiety,
llaril is now also known to be effective
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en the symptoms of anxiety states are
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tation, restlessness, insomnia, somatic
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now that Mellaril may be prescribed—with
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iety alone or a mixture of anxiety
l depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
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Vitamin B_1	7.5 mg
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Vitamin B_{12}	50 mcgm
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Bottles of 60

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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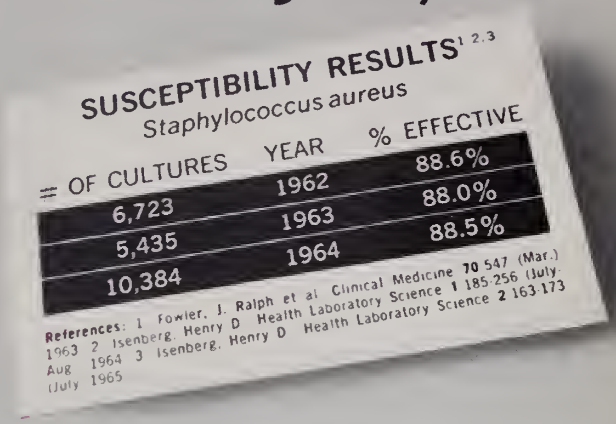
In vitro susceptibility results with TAO® (triacetyl-oleandomycin) in *Staphylococcus aureus* cultures, as shown in studies of antibiotics.



SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

≠ OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J. Ralph et al Clinical Medicine **70** 547 (Mar.) 1963 2 Isenberg, Henry D Health Laboratory Science **1** 185-256 (July-Aug 1964 3 Isenberg, Henry D Health Laboratory Science **2** 163-173 (July 1965

TAO® (triacetyl-oleandomycin)

is a macrolide antibiotic, for use only in the treatment of acute severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to other less toxic agents.

ROERIG
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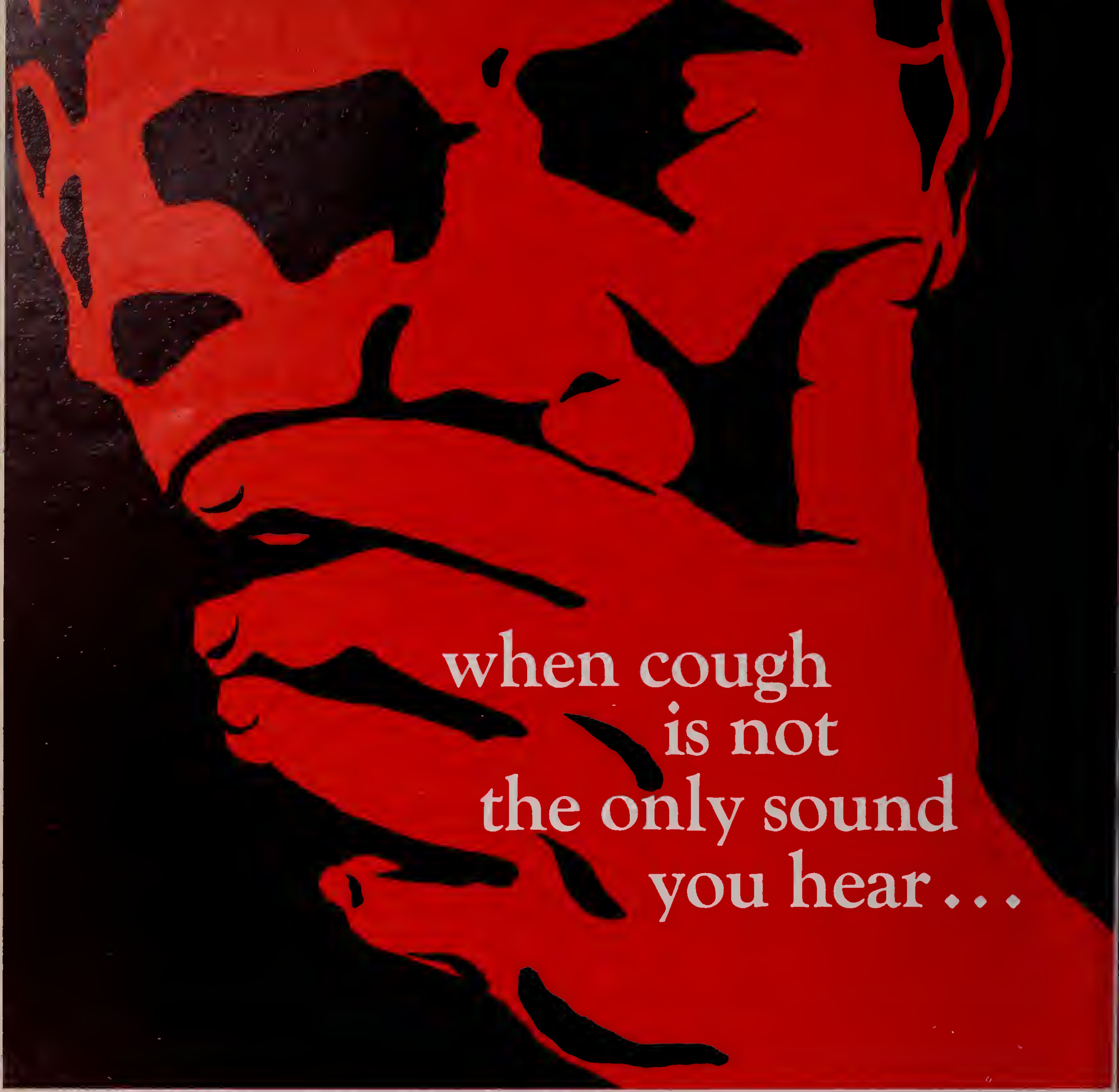
triacetyloleandomycin
250 mg.



OMNI-TUSS® b.i.d.

. . . because OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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In peptic ulcer:

the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

No two women are quite alike...

and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine® Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

It's almost as if you were there to give an injection of penicillin

V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

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Additional information available to physicians upon request.

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Lilly

Concerning Therapy of Candida Fungemia

BY MARY M. CARRUTHERS, M.D.
A. MARTIN LERNER, M.D.
BOTH OF DETROIT

INTRODUCTION

When Candida fungemia is found, removal of the usually culpable intravenous catheter and cessation of antibiotics are indicated. If the patient does not improve, intravenous amphotericin B is instituted.[1-4] Mortality, however, remains high.

Within a 13 month-period, we saw 9 patients with nosocomial Candida fungemias. In each, at least 2 separate blood cultures yielded Candida. Four of the patients who died had received less than 24 hours of therapy with amphotericin B. We suggest prompt institution of small doses of amphotericin when candidemia is documented.

METHODS

Patients were admitted to medical or surgical wards of the Detroit General Hospital. Initially isolations of Candida were made in tryptose phosphate broth. Later, urine, swabs from the throat, feces, or pleural fluids were cultured on Sabouraud's agar. Subsequently, all Candida were transferred to eosin methylene blue (EMB) and Sabouraud's agar. Species were suspected by colonial morphology on EMB agar and characteristics of growth in broth. In most instances fungi were further delineated by biochemical reactions.

CLINICAL FINDINGS (SEE TABLE)

Characteristics of illness are presented in the table. Patients were 18 to 60 years old with a mean of 46 years. Five were women. Cases occurred during every season. Five were chronic alcoholics with abnormal liver function. One was in hepatic coma, and another had marked ascites. One had chronic renal disease with azotemia; 2 others had transiently elevated values of blood urea nitrogen which returned to normal before the onset of their candidemia. Two patients had diabetes mellitus, but their metabolic acidosis was probably renal. Other conditions necessitating hospitalization were empyema, peritonitis, a burn to 30% of the skin, and meningovascular syphilis. None of the patients had malignancies or had received immunosuppressive drugs. One had had corticosteroids. Antibiotics were used by mouth (5 patients) or parenterally by muscle (6 patients) or vein (5 patients). One patient had received 5 agents; three, 4 separate drugs; one, 3 drugs; and one, 2 drugs. Three patients received 1 antibacterial agent. These drugs (ampicillin, cephalothin, chloramphenicol, colistimethate, kanamycin, neomycin, penicillin G, streptomycin, sulfamethoxazole and tetracycline) were given for continuous periods of 6-39 days. Only a 55 year old woman entering in hepatic coma had received neomycin alone by mouth for less than a day. When candidemia was initially documented, all patients were receiving intravenous infusions and most of them by catheter.

Peaks in oral temperature were 102-103°F in 2 patients and 103-106°F in the rest. Moderate to marked anemias (6.5-9.5 gm/100ml) were present in 7 of the 9 patients before onset of fungemias. During candidemias most patients had leukocytoses and all had "shifts to the left." Although 2 patients had initial values of blood urea nitrogen which were transiently over 100 mg%, these returned toward normal before fungemia ensued. Both patients survived. In 3 of the fatal cases progressive azotemia accompanied fungemia. None of these patients had preexisting renal disease, and this organ failure seemed directly related to their candidemias. Serum glutamic oxalacetic transaminases were moderately elevated (less than 200 units) in 2 patients. Four patients with cirrhosis of the liver and one with peritonitis had rises in total bilirubin (2-12 mg/100 ml). Alkaline phosphatase levels were 6.8-26.2 Bodansky units in 3 patients. Hypoalbuminemia (less than 2.5 gm/100

This article was written by Mary M. Carruthers, M.D., during tenure as trainee in infectious diseases and Instructor in Medicine, Wayne State University School of Medicine, and by A. Martin Lerner, M.D., Professor of Medicine and Associate in Microbiology and Pathology, Wayne State University School of Medicine and also Chief of Infectious Diseases and Director of the Bacteriology Laboratory, Detroit General Hospital. The research was aided by a grant (5 T1 AI00261) from the National Institutes of Health. Requests for reprints should be addressed to Doctor Lerner, Wayne State University Medical Research Building, 550 E. Canfield, Detroit, Michigan 48201.

Dr. Carruthers is now Associate in Medicine at Chicago Medical School.

TABLE: Findings in 9 patients with Candida Fungemia at Detroit General Hospital during 13 months of 1966-67

A. HISTORY	
AGE	
Range	18-60 years
Mean	46 "
SEX	
Male	4
Female	5
OCCURRENCE	
February	1 patient(s)
April	2 "
September	3 "
October	2 "
November	1 "
DIAGNOSIS AT ADMISSION	
Chronic alcoholism	5 patients
Cirrhosis with liver failure	2 "
Pyelonephritis	2 "
Diabetes mellitus	2 "
Chronic renal disease with azotemia, empyema, peritonitis, 30% burn, meningovascular syphilis	1 patient ea.
ANTIBIOTICS* GIVEN BEFORE FUNGEMIA	
Number of drugs	
5	1 patient(s)
4	3 "
3	1 "
2	1 "
1	3 "
ROUTE OF ADMINISTRATION	
Intravenous	5† patients
Intramuscular	6 "
Oral	5 "
DAYS OF ADMINISTRATION	
< 1	1 patient(s)
1-8	2 "
9-18	5 "
39	1 "
B. TEMPERATURE AND LABORATORY FINDINGS (DURING CANDIDEMIA)	
Temperature peak °F (orally or equivalent)	
102-103	2 patients
103-106	7 patients
Hemoglobin (grams/100 ml)	
6.5-9.5	7 patients
10-11	2 patients
White blood cell count/ml	
< 10,000	2 patients
10-15,000	5 "
> 20,000	2 "
"Shift to the left"	9 patients
Plasma urea nitrogen (mg/100 ml)	
< 20	5 patient(s)
50-100	3 "
> 100	1 "
Creatinine (mg/100 ml)	
< 2	5 patient(s)
2-5	1 "
> 5	3 "
Serum glutamic-oxalacetic transaminase (units)	
100-200	2 patients
Total bilirubin (mg/100 ml)	
2-12	5 patients
Alkaline phosphatase (Bodansky units)	
6.8-26.2	3 patients
Serum proteins (grams/100 ml)	
Albumin < 2.5	3 patients
Globulin > 3.0	5 "
Yeast in urinary sediment	
Present	2 patients
Absent	3 "
Candida recovered	
Species/deaths	
albicans	4/4 patients
parakrusei	1/1 "
tropicalis	1/0 "
not albicans	3/1 "
Number of isolations from blood	total pts/death
4-6	3/2
3	3/2
2	3/2
Urine	3/1
Throat	1/1
Feces	2/0
Pleural effusion	1/1

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* These included ampicillin, cephalothin, chloramphenicol, colistimethate, kanamycin, neomycin, penicillin G, streptomycin, sulfamethoxazole, and tetracycline.

† All patients received intravenous fluids.

ml) was present in 3 patients, while 5 had hyperglobulinemia (over 3 gm/100 ml). All of these abnormalities in liver function antedated fungemia. Of 5 urines which were examined at times of fungemia, yeast was seen twice.

Species of *Candida* in the blood were *albicans* (4 patients), *tropicalis* (1 patient) and *parakrusei* (1 patient). Three candidemias were species other than *albicans,* but were not further characterized. Every *C. albicans* fungemia was fatal, while 2 of 3 patients with species other than *albicans* and the single patient with *C. tropicalis* sepsis recovered. The *C. parakrusei* infection was also fatal. Urines were cultured in 3 patients and in each, Candida was found. When feces was cultured (twice) or the throat (once), samples yielded Candida. Finally, a *Pasteurella multocida* empyema was superinfected with Candida. Usually within 48 hours blood cultures were positive. Fungemias were repeatedly documented and with a single exception, candidemias were found on at least 2 separate days. Four to 6 cultures from blood were positive in 5 patients, 3 positive in 3 patients and 2 positive in 3 patients. Candidemia was documented for less than 24 hours in 1 case and for 2-12 days in the other 8. Five of 6 patients died whose fungemias were documented for 3 days or less, while 2 of the 3 patients whose fungemias were documented for 7 or more days survived. After the first isolation of Candida from blood, 1 patient lived less than 48 hours while 5 others survived 3-16 days.

TABLE/Continued

C. COURSE

Duration of documented candidemia	total pts/deaths
1 day(s)	1/1
2 "	3/2
3 "	2/2
7 "	2/0
12 "	1/1

D. AMPHOTERICIN B THERAPY

	total pts/deaths
None	4/3
< 24 hours	1/1
48 hours-6 days	4/2

E. DURATION OF ONSET OF CANDIDEMIA TO DEATHS

2 days	1 patient(s)
3 "	1 "
5 "	1 "
9-16 "	3 "
living	3 "

Four patients received no amphotericin B. Three of them died. A 60 year old woman with cirrhosis and *P. multocida* empyema received a single infusion of 15 mg of amphotericin B. before her demise, while 2 of the patients receiving longer courses survived. In 2 of the survivors, initiation of therapy with an initial dosage of 5 mg amphotericin B promptly cleared the blood of fungi. In both patients, where candidemia had previously been found for periods of 48 hours and 7 days respectively, amphotericin B in daily infusions of 15-30 mg was continued for 6 days. Cessation of candidemia in at least one patient, a 45 year old man with pyelonephritis and diabetes mellitus, was not the result of removal of an intravenous catheter. A hectic fever and leukocytosis continued for 2 weeks after intraveous fluids, and all antibiotics were discontinued. *C. tropicalis* fungemia was documented on 4 separate occasions over a 7 day period. After administration of amphotericin B, fungemia ceased.

COMMENT

These patients with candidemias were all debilitated. However, hepatic and renal diseases, diabetes mellitus or other conditions were stable when high fevers and leukocytoses appeared. All had been given intravenous infusions usually by an indwelling catheter. All but one* of the patients had received at least one broad-spectrum antibiotic. *C. albicans*[5] was most virulent, and all of these patients died. Three of the 5 patients with species other than *albicans* recovered. Oligemia or rising azotemia occurred in 3 of the fatalities.

Amphotericin B is indicated in candidemia only after antibiotics are discontinued and infected catheters removed. In one of our patients, candidemia continued for at least 8 days following cessation of intravenous and antibacterial therapy. In 2 of the survivors when amphotericin B was promptly administered small amounts of drug rapidly ended the fungemia. In these amounts there was no toxicity from amphotericin B.

Candida are readily recoverable with routine bacteriologic media from the blood and rarely are contaminants in this site. Yeast probably originated from infected phlebitic veins in patients with intravenous catheters. However, spontaneous gram-negative bacillemias occur in cirrhotics,[6] and although similar candidemias especially in these patients who lack a circulating globulin lethal for *C. albicans* are possible*[7] this remains conjecture. Systemic candidiasis in man may be remarkably similar to the murine model. In both, the kidney is the most vulnerable organ and rapidly progressive renal failure the mode of death. In the mouse after candidemias of 24-30 hours, microabscesses are found in the liver, pancreas, heart, skeletal muscle, and kidney. Occasionally rupture of the fungus into the lumina of the nephron occurs. Within the urine (free of protective globulins in serum) fungi multiply rapidly forming long invasive hyphal elements. Lesions in other organs invariably regress, but occasional recurrent interstitial invasion by hyphae leads to large and lethal cortical and medullary abscesses.[8] An objective of therapy may be to prevent such secondary hyphal invasion of the kidney. Gross and microscopical abscesses in the kidney and brain were demonstrated in one of the fatalities.

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*This patient was receiving 30 million units of intravenous penicillin G daily.

Candidemia should be considered in any patient developing a fever and leukocytosis with an intravenous catheter, especially while receiving antibiotics. The catheter should be removed. A single positive blood culture for Candida suggests that amphotericin B be initiated. Infusions of 15-30 mg daily for about a week have no toxicity, and may be life-saving.

SUMMARY

Nine patients with candidemias were seen at the Detroit General Hospital within 13 months of 1966-67. All had chronic underlying illnesses requiring hospitalization. Hectic fevers and leukocytoses with "shifts to the left" heralded fungemias. Most of the patients had intravenous catheters, and all were receiving antibacterial agents. Corticosteroids were administered to one, but none received immunosuppressive drugs. None had malignancy. Six died after illnesses of 48 hours to 16 days. In at least one of the survivors small doses of amphotericin B induced a prompt remission which did not follow removal of an intravenous catheter and cessation of antibacterial agents.

Since removal of the intravenous catheter followed by a period of observation is not always successful, it is suggested that 15-30 mg of amphotericin B intravenously should be promptly administered when candidemia is confirmed.

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Editorial Comment:

Candida is ordinarily a benign fungus of little consequence. Two factors in modern medical therapy appear to be unleashing a potential danger. These two factors are the use of antibiotics and indwelling catheters. The authors point out warning signs of Candida fungemia, laboratory detection and the need for specific therapy.

—John W. Moses, M.D.,
Scientific Editor

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*Patients with diabetic or renal acidosis as well as others with systemic candidiasis are also deficient in this substance.

Clinical Pathological Conference

This Clinical Pathological Conference at Munson Medical Center, Traverse City, was edited by Richard Wunsch, M.D., Michigan Medicine Associate Scientific Editor of Traverse City

A 56-year-old woman came to the hospital because of fatigue, chronic cough, and hypertension.

During the three years before admission, the patient was aware of progressive fatigue, severe enough to prevent her from performing ordinary household tasks or from walking one to two blocks. Within the last month she developed a persistent non-productive cough and X-rays showed only increased bronchovascular markings. The patient had had hypertension and during a physical examination approximately eight months previously, the blood pressure was 240/130 mm. Hg. Quinidine controlled episodes of tachycardia and auricular fibrillation.

The patient denied pain associated with fatigue. There was no intolerance to cold or heat nor had there been episodes of paroxysmal nocturnal dyspnea. The patient stated that she had had rheumatic fever approximately 20 years ago and ascribed occasional pain in both ankles as an aftermath of that disease. The patient developed what she termed "butterflies" in the abdomen and there were occasional bouts of constipation.

A brother of the patient has diabetes mellitus and another brother and her mother died of coronary thrombosis.

PHYSICAL EXAMINATION

The patient was alert but replied rather slowly to questions. Blood pressure, 148/80, pulse 60 per minute, respirations 20 per minute, weight 179 lbs. There was a suggestion of fullness when examining the thyroid, but nodules were not palpable. The left border of cardiac dullness extended to the left anterior axillary line. The rhythm was normal and a Grade II systolic murmur was heard over the apex and to a lesser extent at the base of the heart. Lungs were clear to percussion and ausculation. Abdominal, pelvic and rectal examinations were normal. The skin felt dry and thickened but there was no edema. The neurologic examination was within normal limits although ankle jerks were not elicited bilaterally.

INITIAL LABORATORY DATA

C.B.C.: Hemoglobin, 15.5 gm/100 ml.; wbc, 13,500 per mm^3 with 8% bands, 63% segs, 1% eosinophils, 3% basophils, 22% lymphocytes, and 3% monocytes.

Urinalysis: Specific gravity 1.012 albumin, trace; other chemical tests normal, 3 to 5 white blood cells per high power field on microscopic examination.

Chemical testing: fasting blood sugar, 92 mg/100 ml; blood urea nitrogen, 45 mg/100 ml; total protein 6.6 G/100 ml; protein electrophoresis, albumin 3.3 G., alpha one 0.03 G., alpha two 0.08 G., beta 0.7 G., and gamma 1.3 G. (all values were within normal limits although the gammaglobulin fraction was at the higher range of normal).

* * *

Maurice Pelto, M.D.,
Radiology Department

X-RAYS

A limited number of radiologic examinations were available. The first, a chest, showed mild to moderate cardiomegaly with left ventricular prominence, and a prominent aortic arch. The hilar shadows were minimally prominent apparently on the basis of enlarged main pulmonary arteries. **(Figure 1)**

Subsequent cardiac films, taken three days later, including obliques with barium, confirmed the prominent aortic arch. Fluoroscopy showed pulsation of the hili favoring prominent pulmonary arteries. They had a somewhat rounded appearance and one could not exclude adenopathy. The enlarged aortic arch with its increased pulsations made

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About the Hospital:

This CPC is from the Munson Medical Center, a nonprofit community hospital at Traverse City, a city of 20,000 on Grand Traverse Bay. The hospital, which serves as a referral center for the area, has 250 beds and a training program with rotating internships.

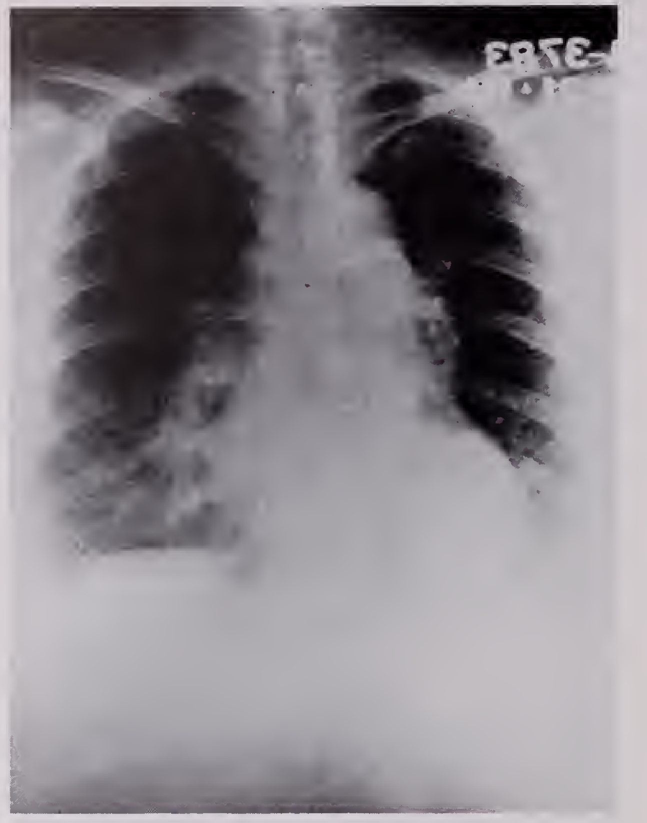

Figure 1

adequate evaluation and differentiation difficult. Laminograms added no further information. An IVP at the time showed mild delay in contrast excretion bilaterally, and was otherwise normal. There was splenomegaly of moderate extent.

Because of the confusion concerning the hili, a miniature chest film taken four years previously was obtained. This showed a similar degree of cardiac enlargement and hilar prominence. In summary, the radiographic examinations showed a moderate cardiomegaly with a widened thoracic aorta, which pulsated prominently. The hili were prominent, the appearance favoring enlarged main pulmonary arteries, with no change in four years.

The kidneys showed mild decreased excretion of dye. There was moderate splenomegaly.

HOSPITAL COURSE

The patient's condition remained unchanged. Additional laboratory studies included: serum calcium 11.9 mg/100 ml. phosphorus 3.3 mg/100 ml., fasting blood sugar 136 mg/100 ml, serum chloride 104 mEq/l, sodium 149 mEq/l, and potassium 4.1 mEq/l. White blood count 18,600 per mm^3 with a normal differential.

Early in the morning of the 10th hospital day she complained of nausea and vomited undigested food. Severe abdominal pain developed and the temperature rose to 101° F. Serum amylase was 2,250 Somogyi units. Serum electrolyte values were in the normal range. Intravenous fluids were administered because of clinical dehydration. On the 11th day, the temperature rose to 106° F. and a repeat serum amylase was 1,330 Somogyi Units. Blood pressure decreased gradually to 86/56 mm. Hg. and the patient was placed in an oxygen tent because of cyanosis. On the 12th day her condition remained critical and urinary output diminished to less than 500 ml. for 24 hours. Serum sodium was 118 mEq/l, chloride 84, potassium 6.9, serum calcium 9.2 mg/100 ml., carbon dioxide content 21.3 mEq/l, serum bilirubin 6.8 mg/100 ml. with a direct fraction of 4.8 mg/100 ml. The temperature remained elevated in the range of 104° to 105° F. She became unresponsive and died on the 12th hospital day.

* * *

DISCUSSION

* * *

Jerold Harwood, M.D.,
Department of Medicine

Fatigue apparently consisting of asthenia and myasthenia was the chief complaint at the time of admission of this middle-aged woman. The protocol does not describe the course of hypertension but does note the occurrence of paroxysmal arrhythmias. The exertional dyspnea and persistent cough suggested mild congestive heart failure. The history of acute rheumatic fever was poorly documented and consists only of sore ankles which had persisted for 20 years. Hypertension and a family history of diabetes mellitus and coronary artery disease established a good background for the presence of arteriosclerotic heart disease.

The physical examination was surprising in that the blood pressure was normal and there were no findings of congestive heart failure except cardiac enlargement. No stigmata of sustained hypertension were described. No neuromuscular abnormality was described except depressed tendon reflexes. The localized thyroid enlargement was interpreted as non-adenomatous for unknown reasons. Laboratory tests established the presence of azotemia, hypercalcemia, hyperglycemia and perhaps a mild hypergammaglobulinemia. The urinalysis did not reflect the severity of the uremia. The chest x-ray was described as showing generalized cardiac enlargement with aortic and pulmonic artery prominence interpreted as aortic valve disease and pulmonary hypertension.

Her terminal course was marked by the development of an acute abdomen with hyperamylasemia, direct hyperbilirubinemia and shock. The sodium, chloride and calcium were all observed to decrease during this period.

The definable problems were the 1) hypercalcemia, 2) acute abdomen, 3) uremia, 4) hypertension, and 5) cardiac enlargement.

Diagnosis of the hypercalcemia was difficult because of only a single phosphorus determination and no alkaline phosphatase measurement. Hypergammaglabulinemia, proteinuria, and a normal serum phosphorus suggested multiple myeloma. The hypergammaglobulinemia of multiple myeloma is usually more dramatic and occurs as a monoclonal spike on electrophoresis. Anemia and rouleaux formations are both manifestations of bone marrow replacement with cells producing abnormal globulin and are not described on our protocol. Sarcoidosis was a possible cause of the hypercalcemia, hypergammaglobulinemia and arthralgias. No hilar or peripheral adenopathy, pulmonary infiltrates or erythema nodosum were present. Minimal pulmonary sarcoidosis can cause a diffusion defect[2] but not pulmonary hypertension.

A history of upper gastrointestinal symptoms suggested the possibility of milk alkali syndrome but would not cause elevation of the serum phosphorus. No history of vitamin D ingestion was available as a possible source of hypercalcemia and this also should cause hyperphosphatemia. Chronic renal insufficiency can result in sustained parathyroid stimulation with the late development of hypercalcemia but always in the presence of, and because of marked hyperphosphatemia. Acute osteoporosis of disuse can not be implicated as a cause of hypercalcemia here. Hyperparathyroidism can not be excluded as the cause of her hypercalcemia. A single normal serum phosphorus does not rule out hyperparathyroidism and multiple phosphorus determinations may be required to demonstrate the hypophosphatemia. I have seen more than one surgically proven hyperfunctioning parathyroid adenoma accompanied by a normal serum phosphorus at the time of admission. The serum chloride of 104 mEq/l is highly suggestive of hyperparathyroidism opposed to hypercalcemic sarcoidosis in which the serum chloride is usually less than 102 mEq/l[9]. Studies of tubular reabsorption of phosphorus would not be of value in this case because of the impaired renal function.

The terminal event was quite dramatic and with its rapid downhill course, acute abdomen, shock, amylasemia and direct hyperbilirubinemia was strongly suggestive of an acute necrotizing pancreatitis. Acute pancreatitis is quite common (12%)[4] in the presence of hyperparathyroidism and may be the presenting event. A decrease in serum calcium due to diminished gastrointestinal absorption occurs in acute pancreatitis and usually parallels the severity of the pancreatitis. This phenomenon is so common that the presence of a normal serum calcium in the presence of acute pancreatitis is highly suggestive of hyperparathyroidism.[6] Acute pancreatitis is uncommon in hypercalcemia not due to hyperparathyroidism and the only case which I have read of was with a multiple myeloma.[1] Pancreatitis may be secondary to uremia of any cause and this should be kept in mind.

Carcinoma of the pancreas secreting a parathormone-like substance resulting in a hypercalcemia is conceivable but I'm not aware of any previously reported cases.

It is difficult to determine the duration of the uremia. Her longstanding, non-specific fatigue could be attributed to it, but chronic renal insufficiency would be expected to have a more striking hyperphosphatemia, hyperkalemia, anemia, hyposthenuria and albuminuria. Chronic glomerulonephritis and pyelonephritis would be expected to follow the latter course. Myeloma kidney or a kidney with glomerular and tubular dysfunction secondary to paramyloid deposits could cause this picture. Apparently benign essential hypertension can result in arteriolonephrosclerosis severe enough to cause renal failure. Renal failure secondary to heart disease is usually precipitated by a marked fall in cardiac output severe enough to cause shock and/or gross pulmonary and/or peripheral edema. No hematuria was present to suggest a primary arteritis which could also cause an acute intestinal event. Hypercalcemic nephropathy may be insidious in its onset and progress to terminal renal failure with a relatively normal urinalysis[3] and no roentgenological evidence of nephrolithiasis or nephrocalcinosis.[5]

The possibility of hyperparathyroidism looks quite strong. If one endocrine adenoma is present, I had best look for another one. Pheochromocytoma has a known association with parathyroid adenoma[7] and would explain the hyperglycemia, intermittent hypertension, paroxysmal arrhythmias and weakness and nervousness. Against this diagnosis is the body weight of 179 pounds which is quite husky for pheochromocytoma. Aldosteronism could account for hypernatremia, hyperglycemia, myasthenia and hypertension, but the normal-to-elevated serum potassium is against this diagnosis. The nephropathy of Conn's syndrome is almost always limited to impaired tubular function with hyposthenuria due to hypokalemia. Essential hypertension or renovascular disease with secondary hypertension are impossible to exclude. Renovascular disease with hypertension is unlikely in that the hypertension is not progressive and apparently preceded the renal disease.

The cardiac enlargement was one of the most difficult aspects of the problem. Arteriosclerotic heart disease unrelated to the other events would be expected to cause angina and more classical congestive heart failure. No physical findings of left ventricular hypertrophy were described so I will assume that the heart was dilated rather than hypertrophied. As mentioned before, it is hard to implicate sarcoidosis. Sustained catecholamine release from a pheochromocytoma can cause myocardopathy. Pheochromocytoma can also metastasize to heart and cause apparent valvular abnormality. Rheumatic heart disease with aortic stenosis and mitral insufficiency could result in the vascular changes described but does not relate to any other of her disease processes. Congenital heart disease with a left to right shunt and secondary pulmonary hypertension would not be expected to have hypertension or aortic prominence. Hypercalcemia can result in aortic valvular calcification and a myocardopathy which is as acceptable as any of the other etiologies mentioned. Cardiac amyloidosis secondary to multiple myeloma could also cause bizarre cardiopulmonary findings including aortic disease, arrhythmias and right sided dilatation with minimal pulmonary disease.

If the patient has a concurrent parathyroid adenoma and pheochromocytoma, the literature says that she must also have medullary carcinoma of the thyroid,[7] and this would account for the enlarged thyroid isthmus.

My diagnosis is Sipple's syndrome[8] or parathyroid adenoma — pheochromocytoma and medullary thyroid carcinoma with secondary acute pancreatitis, myocardopathy and hypercalcemic nephropathy. Second choice is multiple myeloma with hypercalcemia and secondary amyloidosis.

* * *

Laurence P. Skendzel, M.D.,
Department of Pathology

AUTOPSY REPORT

Outstanding gross and microscopic features were seen in the lungs, lymph nodes, pancreas and kidneys. The lungs were not remarkable grossly, but microscopic sections showed non-caseating granulomas composed on multi-nucleated giant cells surrounded by fibrous tissues. There was also an infiltrate of chronic inflammatory cells, chiefly lymphocytes. Sections through hilar lymph nodes showed similar microscopic findings, namely non-caseating granulomas, and in one of these, an asteroid body was seen. Stains for acid fast organisms and fungi were negative.

The pancreas was removed with difficulty because of adherence of its surface to the mesentary and loops of small and large intestine. The peritoneal surface overlying the pancreas was discolored and dark red; and there were numerous bright yellow foci of fat necrosis. The weight of the pancreas was 300 grams and included a moderate amount of soft tissue surrounding the head. Cut section showed discrete pancreatic lobules but the major portion of the pancreas was mottled red and green with a loss of normal architecture. Microscopic sections confirmed the gross impression of acute necrotizing pancreatitis.

Microscopic section of kidney showed focal glomerular thickening characterized by irregular deposits of pink staining material. Congo red and crystal violet stains were negative and ruled out the possibility of amyloidosis. The homogenous refractile material was positive with PAS stains. Microscopic findings were those of a focal glomerulonephritis characterized by thickening of glomerular walls. There also were calcific deposits in the interstitium of the kidney and arterioles were thickened considerably with narrowing of the lumens. The glomerular lesions were not classified. Focal glomerulonephritis can occur as a complication of a great variety of infections, chemical poisoning, or an allergic reaction to drugs. The thyroid was not enlarged nor were microscopic sections unusual. Only two parathyroids were identified at the time of autopsy and they were not enlarged.

The heart weighed 460 grams and the right ventricular wall was 0.4 cm. thick and the left ventricular wall, 1.2 cm. thick. Cross sections of the coronary artery shows that the lumens were patent. Microscopic sections of the heart were not remarkable. On examination of the lung, focal arteriosclerosis was noted in the pulmonary arteries. There was no significant enlargement of the major pulmonary arteries at the hilum.

The microscopic findings in the lungs and lymph nodes were consistent with sarcoidosis. We attributed hypercalcemia to sarcoidosis and the serum calcium concentration decreased with the onset of acute pancreatitis. We were aware of the association between hyperparathyroidism and pancreatic disease, but a review of the literature does not reveal a correlation between sarcoidosis and acute pancreatitis.

FINAL ANATOMIC DIAGNOSES:

1. Sarcoidosis involving lungs and hilar lymph nodes.

2. Acute necrotizing pancreatitis with fat necrosis of peri-pancreatic tissue, omentum, and mesentary of small and large intestine.
3. Focal glomerulonephritis.
4. Arteriolar nephrosclerosis.
5. Enlargement of the heart, slight, weight 460 grams.

* * *

FURTHER DISCUSSION

A physician:

In retrospect, what clues suggested the diagnosis of sarcoidosis?

Doctor Harwood:

Hypergammaglobulinemia and hypercalcemia would make you consider this diagnosis. The features against sarcoidosis are the elevated serum chloride level, about 104 mEq/l, the fact that acute pancreatitis has not been described in association with sarcoidosis. This would be a reportable case except for the fact that all the parathyroid glands were not identified.

A physician:

We are aware of the association of parathyroid tumors in pancreatitis, and one wonders if the high calcium level is responsible for acute pancreatitis?

Doctor Harwood:

Acute pancreatitis associated with hyperparathyroidism is due to a direct action of parathyroid hormone on trypsin activation in the pancreas. The calcium level is not responsible for the acute pancreatitis.

Doctor Pelto:

I'm wondering if the prominence in the hilar regions were lymph nodes instead of pulmonary arteries. I have a feeling that the one feature that led the Discussant astray is the confusion of enlarged pulmonary wessels with hilar adenopathy.

Doctor Skendzel:

There was no enlargement of the pulmonary arteries. The autopsy protocol does not include the measurement of lymph nodes, but I assume that they were enlarged.

A physician:

I have a young woman with asymptomatic sarcoidosis and a proven Kviem test. Chest X-Rays on two occasions have shown prominent pulmonary arteries.

A physician:

One interesting feature that I have seen before in sarcoidosis is dyspnea which can not be explained on the basis of pulmonary findings. The enlarged spleen noted on the I.V.P. is another possible clue of sarcoidosis.

Doctor Harwood:

Pulmonary function tests would have been extremely valuable in this case. In the *"Annals of Internal Medicine"* a study showed that with either minimal sarcoidosis or extensive sarcoidosis which has been treated and dissolved, there is a persistent pulmonary defect even though the pulmonary architecture is not remarkable.

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The Physician as a Life-Long Student

BY MILFORD O. ROUSE, M.D.
AMA PAST PRESIDENT
DALLAS

The true physician is a student as long as he accepts the responsibility of practicing medicine. Even if the store of medical knowledge were not doubling every ten years — as has been estimated, it would be impossible for any human brain to absorb and retrieve all of the scientific knowledge requisite for the "complete" practice of medicine. The physician, therefore, learns the essentials or fundamentals of medicine and where to go for special information, and then relies on his judgment and his sincere desire to "keep-up" to enable him to continue to meet faithfully his obligation in handling the problems of health of his fellow citizens.

Therefore, postgraduate or continuing education is a vital necessity for every physician.

In addition to the every day opportunity to learn from his patients and from his fellow physicians, a doctor should also have a definite program of continuing education by scientific reading. His county medical bulletin, his state medical journal, the Journal of the American Medical Association, his specialty journal (if he is in a specialty) ought to be the minimum — with at least a couple of hours set aside each week to at least scan through these journals.

The scientific programs of his county society; annual meeting of his state association; the annual and clinical sessions of the AMA and the meetings of his specialty groups afford a wonderful opportunity to get a condensed review of both fundamentals and advancements in the fields in which the physician is particularly interested.

The American Academy of General Practice set the first example of requiring a minimum amount of postgraduate work as a basic requirement for continued membership in the organization, and other medical groups are considering the same principles. Most of our medical schools have excellent programs of continuing medical education, and many specialty groups sponsor one week or more organized postgraduate work one or more times each year.

One interesting advance has been the utilization of closed circuit television — not only from hospital or medical school to assembly hall or hotel room during medical meetings, but now from a medical center to a county medical society, as was recently successfully demonstrated between the Southwestern Medical School Faculty in Dallas and a group assembled at Sherman, Texas, for the Blackford Memorial Lectures, where a clinical pathological conference was staged in the most successful and interesting manner, with questions and comments both from the audience in Sherman and the team in Dallas.

The American Medical Association is working on plans of formal recognition of regular postgraduate work by physicians, probably as a plaque to go on the physician's wall.

Meanwhile, the true physician regards continuing medical education not only as an obligation, but as a tremendously interesting privilege.

(Editor's Note: This article was prepared by Doctor Rouse especially for Michigan Medicine).

Tumors of Major Salivary Glands In Children

BY KLAUS HOFFMANN, M.D.
MELVIN A. BLOCK, M.D.
BOTH OF DETROIT

Except for hemangioendotheliomas, angiomas, and other congenital lesions which usually are evident during the first year of life, the spectrum of disease processes producing tumors of the major salivary glands in children is similar to that in adults.

Our experience emphasizes that unless management of salivary gland lesions in children follows the principles established for their proper treatment in adults, recurrence rates and the incidence of poor therapeutic results are high. Thus, tumors of the parotid gland in children require more than a local excision; i.e., at least a partial or superficial parotidectomy should be performed.

MATERIALS AND METHODS

In a review of the experience with lesions of the major salivary glands at the Henry Ford Hospital from 1944 through 1966, 22 patients were under the age of 16 at the time the tumors of these glands were recognized. All patients with acute inflammatory processes involving the salivary glands were excluded. All lesions occurred in the parotid gland except for three patients in whom the submaxillary gland was involved. This distribution of the various pathologic entities in the 22 patients is shown in **Table I.**

Follow-up periods varied from 2 to 23 years, with an average of 13 years. The operative procedures, along with the results of treatment and the length of follow-up periods, are shown in **Table II.**

RESULTS

Since a total of 440 tumors of the parotid and submaxillary glands were treated at the Henry Ford Hospital from 1944 through 1966, approximately 5 per cent of all patients with tumors of the major salivary glands were 16 years of age or less. This figure agrees with that of other investigators.[1]

Of the four patients with persistent salivary gland enlargement due to chronic sialadenitis, three required resections because of persistent symptomatic enlargement. In one of the patients, ductal obstruction, due to a stone, was shown to be the etiologic factor. The additional patient, who did not require an operation, had bilateral parotid involvement. Antibiotics were used in treatment.

As shown in **Table II**, problems in treatment were concerned primarily with mixed tumors and mucoepidermoid tumors in children. Difficulty occurred as a result of inadequate initial operative procedures.

Of seven children having mixed tumors of the parotid, two were seen initially because of local recurrence following a previous local excision. One of these patients had been operated for a mixed tumor on two previous occasions. Wider excisions, usually a subtotal parotidectomy, has not been followed by further difficulty for follow-up periods of 3 to 18 years.

All four children with mucoepidermoid tumors were seen because of recurrence, for the third time in one patient, following previous excisions. In one patient, cervical lymph node dissection for metastatic spread was necessary at the time of reoperation.

DISCUSSION

The frequency of occurrence and high recurrence rate of mixed tumors and mucoepidermoid tumors, after local excision of salivary gland tumors in children was striking in this review. The potential danger of salivary gland tumors in children is emphasized.

A tumor of a major salivary gland in infancy can be expected to be a hemangioendothelioma or angiomatous lesion of congenital origin. Kauffman and Stout report benign hemangioendotheliomas to be the dominant tumors of the parotid in the first year of life.[2] They point out that this pathologic entity is the most striking feature distinguishing parotid tumors in infants and children from those occurring in adults. Surgical removal of hemangioendotheliomas, hemangiomas,

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TABLE I. LESIONS OF PAROTID AND SUBMAXILLARY GLANDS IN 22 PATIENTS UNDER THE AGE OF 16 YEARS.

	LESION	NO. PATIENTS	AGES
I. Infancy and early childhood	Hemangioendothelioma	2	1-2 mo.
	Lymphangioma	1	3 yr.
II. Childhood	Chronic sialadenitis, non-specific*	4	6-16 yr.
	Tuberculous sialadenitis	1	7 yr.
	Simple cyst	1	6 yr.
	Epidermoid cyst*	1	9 yr.
	Mixed tumor*	7	8-16 yr.
	Mucoepidermoid tumor	4	11-14 yr.
	Acinar cell carcinoma	1	13 yr.
TOTAL		22	

*One each of these categories occurred in submaxillary gland.

TABLE II. OPERATIONS AND RESULTS OF TREATMENT FOR MAJOR SALIVARY GLAND LESIONS IN CHILDREN.

LESION	NO. PTS.	ORIGINAL OPERATION	RECURRENCE	FINAL OPERATION	CURRENT STATUS	LENGTH OF FOLLOW-UP (YR.)
Hemangioendothelioma	2	Part. parotidect.	No (2)	———	No rec.	3-15
Lymphangioma	1	Superficial parotidect.	No	———	No rec.	2
Chronic sialadenitis, non-specific	4	Subtot. parotidect. (2) Excision submax. gland (1) No operation (1)	No (4)	———	No rec.	6-19
Tuberculous sialadenitis	1	Subtot. parotidect.	No	———	No rec.	13
Simple cyst	1	Superficial parotidect.	No	———	No rec.	2
Epidermoid cyst	1	Excision submax. gland	No	———	No rec.	10
Mixed tumor	7	Local excision (4)	Rec. (2)*	Subtot. (2) parotidect.	No rec.	4-22
		Excision submax. gland (1)	No	———	No rec.	
		Subtot. parotidect. (2)	No	———	No rec.	
Mucoepidermoid tumor	4	Local excision (4)	Rec. (4)**	Subtot. (2) parotidect. Total (2) parotidect.	No rec. in 3, 1 lost to follow-up	2-20
Acinar cell carcinoma	1	Superficial parotidect.	No	———	No rec.	4

*In one patient, recurrence developed on 2 occasions after local excisions done prior to subtotal parotidectomy.

**In one patient, recurrence developed on 3 occasions after local excisions prior to more madical operations. Neck dissection also done in 1 patient having cervical node metastases.

and lymphangiomas is avoided if possible during the first two years of life since facial nerve damage is prone to occur and some of the lesions will regress. A small incisional biopsy is performed to eliminate the possibility of a rare sarcoma or embryoma which should be totally removed by parotidectomy.[3] Early removal of benign congenital lesions may be necessitated because of size, ulceration, or hemorrhage.

Except for the finding of undifferentiated carcinoma occurring more frequently in childhood (beyond infancy) than in adults, the spectrum of pathology and the clinical behavior of lesions of major salivary glands is the same in children as in adults.[2] Chronic sialadenitis can produce persistent tumefaction and constitutional symptoms in children as well as in adults. Blatt states that benign lymphosialadenopathy in children is characterized by a non-obstructive peripheral duct sialectasis.[4] However, chronic sialadenitis of the submaxillary gland in a 16 year old boy in our group was associated with a stone in the duct. Total extirpation of a submaxillary gland because of repeated inflammatory exacerbations associated with a calculus was also required for a seven year old patient reported by Doku.[5] As Beahrs, Devine, and Woolner point out, parotidectomy is indicated when symptoms of chronic or recurrent sialadenitis are severe and do not respond to conservative treatment.[6] Blatt also emphasized that recurrent and persistent parotid lymphadenitis can result from animal scratches.[4]

Karlan and Snyder emphasize that chronic sialadenitis causes the majority of persistent salivary gland enlargements and can usually be managed satisfactorily by observation and antibiotics.[7] Extensive parotid surgery for inflammatory lesions is associated with a greater risk of facial nerve damage in children. In general, chronic inflammatory lesions of the salivary glands were not included in this series unless the persistent enlargement produced significant symptoms or problems in differentiation from a neoplasm.

The histologic identity of discrete nodules or tumors of major salivary glands cannot be defined with certainty except by study after surgical removal. Therefore, all such gross lesions in the parotid should be treated by at least a superficial parotidectomy (removing the portion of the gland superficial to the facial nerve) and those in the submaxillary gland by total excision of this gland, as the minimal operative procedure. This study emphasizes the necessity for this policy in children as well as in adults. A high local recurrence rate, metastatic spread, or other complications occur following removal of mixed tumors, mucoepidermoid tumors, or more virulent lesions, or more malignant lesions unless this policy is followed in operative procedures for all ages beyond infancy. Every effort should be made to preserve the facial nerve and its major branches, if these are not involved as evidenced by pre-operative or operative findings. Of course, preservation of branches of the facial nerve can necessitate a more tedious and difficult dissection in young children. Tumors of the deep portion of the parotid gland are rare; these require removal of this portion of the gland by an approach through the neck.

It is true that discrete small tumors projecting from the lower pole of the parotid can occasionally be adequately removed by a wide excision of the lower half of the gland (partial parotidectomy) after proper visualization of the facial nerve and its branches. Also, in rare instances incisional biopsy is indicated to determine the nature of large diffuse lesions in infants or young children to support a policy of continued conservative treatment for a chronic inflammatory process. Sialograms are also of help in such problems. Thus, experienced surgical judgment modifies treatment, but the policy stipulated in the above paragraph should be the basic plan of management of parotid tumors in children.

Nodules located posterior to the angle of the mandible should be considered to be parotid tumors in their initial management. Although a nodule in this location can be an enlarged lymph node, it is more likely to be a tumor of the parotid gland, in our experience. Therefore, mere enucleation of such lesions under local anesthesia should be avoided. Adequate removal of parotid tumors in this posterior location requires general anesthesia and, at least, a superficial parotidectomy.

The clinical course of the various salivary gland tumors in children also appears to be similar to that for adults. Thus, long periods of follow-up are required before cure of certain lesions, such as mixed and mucoepidermoid tumors, is certain. Kauffman and Stout did not encounter a mixed tumor of a major salivary gland in a patient less than 7 years old; this conforms with our experience.[2] Mixed and mucoepidermoid tumors usually enlarge slowly.

Except for the problem of local recurrence and metastatic spread, postoperative complications in the children with major salivary gland lesions were minimal in the group of patients in this study. Two patients had transient facial weakness following superficial parotidectomy for mixed tumor, one of these patients also developing gustatory sweating (Frey Syndrome).

Of course, a variety of benign and malignant lesions, not represented in this study, can occur in the major salivary glands in both children and adults. Some of these have been noted in several reports which indicate their rare occurrence.[8-10] The parotid glands may be diffusely enlarged as a result of involvement by systemic disease such as sarcoidosis. A parotid tumor may be simulated by underlying mandibular tumors, primary or metastatic, which push the parotid anteriorly.

SUMMARY AND CONCLUSIONS

1. In an evaluation of 22 patients, who were 16 years of age or less at the time of recognition of tumors in their major salivary glands, the spectrum of the pathology of lesions, excluding acute inflammatory processes, corresponded to that for adults, except that hemangioendotheliomas and congenital angiomas predominated in infancy and early childhood.

2. Tumors of the major salivary glands require, in general, an initial wide excision by at least a superficial parotidectomy or excision of the submaxillary gland. Enucleation, or other inadequate surgical procedures, has resulted in the past in a high recurrence rate of salivary gland tumors in children. This was especially emphasized in the commonly occurring mixed and mucoepidermoid tumors. Thus, the surgical principles of management of salivary gland tumors in adults applies equally to children.

3. Chronic or recurrent sialadenitis, not responding to medical measures, occasionally requires operative treatment in children.

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An Unusual Case of Middle Ear Injury

BY JACK CAMPBELL, M.D.
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A recent comprehensive article in the Laryngoscope, June 1968, by Hough and Stewart[2] indicates the infrequent recording of conductive lesions due to middle ear injuries. This article is chiefly devoted to those cases in which middle ear injuries are found associated with severe injuries where skull fractures are encountered, et cetera. Our report is of traumatic injury to the external auditory canal with middle ear injury.

The patient was a white male, age 24, who was a repairman for the telephone company. On 11/30/67 he was admitted to the Out Patient Department of the hospital, roughly two hours after the following had taken place: at 11 a.m. he was disconnecting a telephone line at the side of a house and while reaching a twig of a tree around which he was working penetrated under his cap and into his ear canal. Immediately he sustained severe pain and severe vertigo. He fell to the ground and after the vertigo maintained itself, he managed to crawl to the company truck and use the mobile phone to call for medical aid. He had no severe bleeding at the time, complaining only that he had severe vertigo. He was unable to stand without putting his arms out from his sides to steady himself in space and, of course, he heard very poorly.

He was examined rather promptly in the Out Patient Department admitting room and was found to have a traumatic perforation of his right tympanic membrane after the twig had deflected from the anterior wall of the external auditory canal. Furthermore, with microscopy, it was noted that there was an incudo-stapedial dislocation.

Two days after his admission, because of the obvious involvement of his vestibule, secondary to his trauma, and when we were more reasonably certain that we had protected him from tetanus and infectious labyrinthitis, etc., he was taken to the operating room. Under local anesthesia a tympanomeatal flap was developed with some difficulty because of the trauma involving the external auditory canal. After reflecting this forward and controlling the bleeding with adrenalin tampons, the posterior canal wall was taken down in the usual manner and we were able to visualize the problem: he had dislocated both the incus and the stapes.[3] The incus was no longer in continuity with the stapes and the stapes was rotated 45 degrees toward the promontory and depressed into the vestibule slightly. The sacule did not appear to be injured from the trauma, however, following removal of the stapes.

It was my belief, at the time, that the incus was fractured and a stainless steel prosthesis gelfoam wire was placed from the long process to the oval window. It was difficult for us to identify the malleus handle adequately because of the traumatic condition of his tympanum and we were not as hopeful that a prosthetic device from the malleus to the oval window would work as well as one from the incus to the vestibule. The incus was so mobile, however, we were unable to use a stainless steel pre-formed gelfoam prosthesis, so an aluminum teflon piston was used, as this has a grasp application and we were able to tighten this over the neck of the incus and place it over a compressed gelfoam pad, maintaining the position of the incus in its normal position and place it over a compressed gelfoam pad covering the oval window, using a modification of a consistently effective procedure restoring the sound conduction to the oval window, as outlined by Dr. Howard House.

Following this procedure, we then anesthetized the pretragal area and the tragus was exposed and the upper half excised. The perichondrium was stripped from this. One-half of this was compressed, after thinning, and placed under the tympanic membrane, after we had first placed gelfoam soaked in Chloromycetin otic into the middle ear space. The tympanic defect seemed to be covered nicely this way and this same "slush" was then used as a retainer of the tympanomeatal flap, after it was reflected into its normal position. A mastoid dressing was applied and the procedure was terminated.

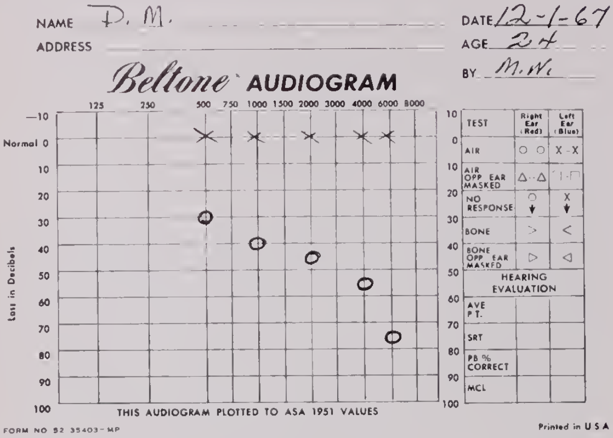

FIGURE 1

An audiogram done prior to his surgery (**Figure 1**) indicated a rather severe hearing impairment with evidence of probable injury to the sensorineural mechanism. Because of his hearing loss and because he had had previous audiometric evaluation at the University of Michigan, we obtained a copy of the work done there in June 1965. The final diagnosis of their department was chronic sinusitis and possible mild high tone sensorineural deafness. This then made us cognizant to the fact that he had perhaps had some pre-existing problem in his ear. However, after obtaining their records, we found that they were concerned with his left ear and his trauma was to his right ear. Thus, we were forced to conclude that he did not have a pre-existing sensorineural hearing loss to his injured ear.

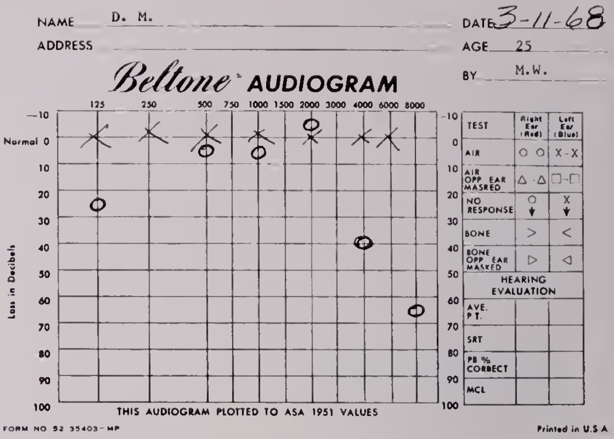

FIGURE 2

An audiogram (**Figure 2**) three months after his surgery will indicate complete recovery through the speech range of his hearing loss. Moreover, it will be noted that he had some recovery in the area most concerned about in acoustic trauma, 4000 cycles, but still showed evidence of sensorineural damage.

The important features of the management of the case, of course, were that his vertigo was almost non-existent within three days after surgery and that he had an uneventful recovery with a non-infected middle ear cavity and labyrinth following surgery. Further, he had a salubrious response to his graft and prosthesis. The patient was returned to his normal occupation in a six week interval and as far as he is aware, his hearing is normal binaurally.

Summarily, a brief resume of the handling of traumatic ossicular[4] disruption and dislocation combined with tympanic perforation with present day microsurgery is presented.

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Acute Mumps Meningitis

BY CARLOS A. PHILIPPON, M.D., F.A.A.P.
ALMA

Acute mumps meningitis is a relatively common, benign and short lived complication of mumps virus infection. The condition should not be confused with mumps encephalitis which is more severe, carrying a 20% mortality and a higher incidence of neurologic sequelae (ataxia, hemiplegia, spastic triplegia, etc.).

The purpose of this report is to call attention to this entity that may go undiagnosed unless sought for.

MATERIAL

This small series consists of 8 cases of acute mumps meningitis (**Table 1**) drawn from a single Pediatric Practice and seen at Gratiot Community Hospital in Alma between the months of February and May of 1968.

There were 6 males and 2 females, in keeping with the reported preponderance of males over females at a ratio of 5:1. The age ranged from 4 to 12 years.

TABLE 1

Symptoms	No. of Cases
Headaches	8
Vomiting	8
Fever	8
Malaise	8
Stiffneck	8
Photophobia	7
Parotid Swelling	6
Dehydration	5
Convulsions	0

CLINICAL SYMPTOMS

All 8 cases had an abrupt onset of illness with fever, headaches and vomiting followed within 24 hours by mild stiffness of the neck and photophobia.

Signs of meningeal irritation were elicited in all on admission. The onset of CNS involvement followed the parotid swelling for 7 days in 3 cases, 2, 5 and 10 days in another 3. One never developed glandular swelling and in 1 case parotitis appeared on the right side 3 days after the CNS symptoms and on the left 3 days after the right.

LABORATORY FINDINGS

As can be seen in (**Table 2**) all 8 cases had spinal fluid pleocytosis ranging from 84 to 1450 with a lymphocytic preponderance in 6.

As expected Protein and Sugar were normal or slightly elevated and all cultures were negative. Case 3 is included even though the CSF was normal, because the patient had all the clinical features already described.

Table 3 depicts the results of the CBC's showing a tendency to a mild leukopenia, the lowest being Case VIII with 2800 cells. A polymorphonuclear leukocytosis on the peripheral smear is present in most cases.

Virus isolation was attempted in 3 cases by forwarding the CSF to the Bureau of Laboratories, Michigan Department of Health. All 3 cases were negative. This failure to isolate mumps virus may

TABLE 2

		Aspect	T. Cells	WBC	RBC	Pol.	Lym.	Pr.	Sugar	Culture
Case I	Initial	clear	220	220	0	213	7	29	87	neg.
	2 days	clear	526	526	0	285	141	25	95	neg.
Case II	initial	clear	84	84	0	6	78	37	78	neg.
Case III	"	clear	7	7	0	1	6	25	100	neg.
Case IV	"	sl. cloudy	1452	1452	0	0	1452	53	95	neg.
Case V	"	clear	403	403	0	0	403	37	90	neg.
Case VI	"	clear	1238	1205	33	0	1205	78	78	neg.
Case VII	"	clear	397	397	0	234	163	29	73	neg.
Case VIII	"	clear	628	628	0	214	414	70	73	neg.

cerebrospinal fluid results

TABLE 3

	Hemoglobin	WBC	Polys	Lymphs.	Eos.	Monoc.	Basoph.
Case I	15.2 gm%	15.100	89%	11%	—	—	—
Case II	13.6 "	6.400	52%	46%	2%	—	—
Case III	13.7 "	4.600	79%	21%	—	—	—
Case IV	14.4 "	6.100	31%	65%	1%	3%	—
Case V	11.4 "	5.800	78%	22%	—	—	—
Case VI	12.4 "	6.550	56%	44%	—	—	—
Case VII	12.8 "	10.700	80%	19%	—	1%	—
Case VIII	12.4 "	2.800	60%	37%	2%	1%	—

CBC results

have been due to our faulty handling of the specimens. Complement fixation titers were obtained in 2 cases, both with positive result thus confirming the clinical diagnosis. The test was crucial in Case I in whom parotid swelling never developed.

HOSPITAL COURSE AND TREATMENT

Clinical symptoms subsided within a week in all cases except one who remained febrile for 8 days.

Convulsions occurred in none nor were there any signs of neurologic sequelae at the time of discharge.

None of the cases had papilledema or evidence of increased intracranial pressure.

The treatment consisted of symptomatic and supportive measures. Analgesics and antipyretics were used as needed and, only occasionally, mild sedation with a short acting barbiturate.

All cases obtained temporary relief from headaches at the time of the lumbar puncture.

Five children required intravenous fluids to correct a mild to moderate dehydration and persistent vomiting.

COMMENTS AND DISCUSSION

Acute mumps meningitis is a complication of the mumps (myxovirus) infection that follows a rather typical clinical pattern of sudden onset of illness with fever, headaches, vomiting, variable degree of stiffness of the neck and signs of meningeal irritation on physical examination.

It usually appears 7-10 days after the glandular involvement although it may precede, manifest during or without any evidence of parotitis.

The absence of cerebral symptoms points to a pure meningeal involvement.

The cerebrospinal fluid shows pleocytosis with normal or elevated Sugar and Protein. These findings alone are, of course, not diagnostic since aseptic meningitis of other etiology will present the same changes.

It is estimated that between 35 and 65% of cases of mumps will show CSF pleocytosis if tested routinely so that this finding becomes even less specific.

The presence of the typical clinical picture during an epidemic in the community coupled with glandular involvement warrants the diagnosis of acute mumps meningitis.

In those instances where one or more criteria are missing confirmation must be obtained by virus isolation or serologically with complement fixation titers.

A leukocytosis with neutrophilia in the peripheral smear is described as present during the initial, acute stage of the disease. Our cases had a tendency to a mild leukopenia that was pronounced in one instance. There was relative neutrophilia in most. The true incidence of this complication is difficult to ascertain because of the varying reports including those from the Communicable Diseases Center of the U.S. Public Health Service. When the cases are reported from the local level they are included under the heading of "Encephalitis of a post-infectious nature" and I imagine that by so reporting we have added 8 more cases of "Encephalitis" to the National Registry.

Mumps meningitis is, nevertheless a common condition. Among 511 cases of acute CNS diseases of viral etiology reviewed by Lennette and coworkers they found 42 cases or 8% to be due to mumps. At the local level, according to the Monthly Surveillance Report by the Michigan Department of Public Health (*Michigan Medicine* —906—July 1968) there were 11,808 cases of mumps in the first 5 months of 1968 as against 10,512 for the same period in 1967.

Forty-seven cases of Encephalitis are listed but without giving the etiology.

SUMMARY

Thus, to conclude: a youngster who, during an epidemic of mumps has been exposed to, or has mumps parotitis and develops a sudden illness characterized by fever, headaches, vomiting and stiffness of the neck very likely suffers from mumps meningitis and deserves a lumbar puncture. This latter procedure will accomplish threefold:

1. will rule out a purulent or bacterial meningitis
2. will confirm the clinical diagnosis and
3. will temporarily relieve the patient's cephalalgia.

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* * *

APPENDIX

REPRESENTATIVE CASES

CASE I is an 8-yr.-old Caucasian male who was in his usual state of health until 24 hours prior to admission when he suddenly developed fever. Within the next 12 hours he complained of severe headaches and vomited once.

When examined on the day of admission he was alert with no cloudiness of his cerebral faculties. The temperature was 102 rectally. There was stiffness of the neck but without rigidity. Brudzinski, Kernig and "tripod" signs were present. The optic fundi were normal. A lumbar puncture disclosed clear CSF with 220 white cells of which 213 were neutrophils and 7 lymphocytes.

A second spinal fluid 2 days later again showed pleocytosis of 526 with 285 polys and 141 lymphs. Protein and Sugar were normal. The youngster remained febrile, complained of severe headaches and photophobia but mentation was normal at all times.

A complement fixation titer for mumps virus in serum showed an acute phase sample of 1:8 and a fourfold rise to 1:32 in 3 weeks. The patient recovered uneventfully and without sequelae.

COMMENT: this interesting case began with a picture of aseptic meningitis of viral etiology, the ultimate diagnosis unfolding only when the serology revealed the presence of rising titers for mumps.

CASE VII: This 4-yr.-old Mexican-American male youngster was well until the night prior to admission when he suddenly developed fever, headaches and vomiting. By the next day he continued ill having now complained of photophobia.

He was known to have been exposed to mumps in the previous 2 weeks by two siblings.

Initial examination revealed fever of 102.2, lethargy but with normal mental faculties. Signs of meningeal irritation were elicited: Brudzinski, Kernig and nuccal stiffness.

The parotid regions were normal with no evidence of swelling or tenderness.

By lumbar puncture clear CSF was withdrawn containing 397 cells of which 234 were neutrophils and 163 lymphocytes.

Sugar 73 mg. % and Protein 29 mg. %. The hemoglobin was normal and the WBC showed 10,700 cells with 80% neutrophils and 19% lymphocytes, 1% monocytes.

Three days after admission and with the above clinical picture only slightly improved he developed parotid swelling and tenderness on the right, followed, three days later, by left sided parotitis.

Acute phase complement fixation titer of 1:8 with a convalescent titer of 1:128 were obtained.

He recovered without sequelae after 8 days of low grade fever, malaise and intermittent headaches.

COMMENT: This youngster developed the complication before the appearance of the glandular involvement thus indicating the wide spread distribution of the virus before localizing the disease to the parotid glands.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING NOVEMBER 2, 1968

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	21	31	296	971
Whooping Cough	21	90	378	905
Diphtheria	0	0	0	1
Mumps	294	901	13545	14103
Scarlet Fever & Strep Sore Throat	713	860	8365	11048
Tetanus	1	1	3	3
Poliomyelitis (Paralytic)	2	0	2	3
Hepatitis	283	194	1900	1658
Salmonellosis (Other than S. typhi)	56	91	545	505
Typhoid Fever (S. typhi)	0	1	0	8
Shigellosis	50	56	258	373
Aseptic Meningitis	50	22	234	70
Encephalitis	20	11	89	97
Meningococcic Meningitis	4	6	78	64
Influenzal Meningitis	10	7	52	50
Tuberculosis	256	306	2365	2512
Syphilis	545	588	4593	4790
Gonorrhea	1891	1645	15275	14383

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Xanthogranulomatous Pyelonephritis

ABSTRACT: A case of xanthogranulomatous pyelonephritis in a fifty-five year old female is presented to document the rapid progression of this disease during a forty-five month period. This destructive inflammatory process is usually unilateral and associated with a Proteus infection. At times the gross and radiologic picture may resemble a renal tumor; furthermore, the microscopic appearance of the large vacuolated foam cells has been confused with the clear cells of hypernephroma. Treatment usually consists of nephrectomy of the affected side.

BY MARK C. MC QUIGGAN, M.D., F.A.C.S.
HENRY Y. LIU, M.D., F.A.S.C.P.
BOTH OF SOUTHFIELD

Xanthogranulomatous pyelonephritis is a destructive disease of the kidney which may mimic renal carcinoma in its pyelographic as well as its gross and microscopic appearance.[1, 2, 3] While the end result of this disease is usually a functionless kidney the rate of progression of the disease has not been determined. This case is being presented to document the possible rapid progression of this disease. Minimal caliectasis in the upper pole of the kidney was demonstrated on a pyelogram taken forty-five months prior to admission. These minimal inflammatory changes progressed rapidly to total destruction of the kidney.

CASE REPORT

P.T. (No. 090047) is a 55-year-old Negro female who was admitted to Providence Hospital on December 20, 1967 with a history of a urinary tract infection which did not respond to antibiotic therapy. An intravenous pyelogram on December 11, 1967 demonstrated non-visualization of the left kidney and minimal caliectasis in the right upper pole.

In 1964 this patient underwent urologic investigation for a similar problem. An intravenous pyelogram obtained on March 16, 1964 demonstrated minimal caliectasis on the left (**Figure 1**). At cystoscopy, findings compatible with chronic cystitis were noted. At this time the patient responded well to antibiotics and remained asymptomatic until about six months prior to admission when she began to experience bladder irritative symptoms. She did not seek medical advice until one month prior to admission.

A blood pressure of 140/90 was noted. The rest of the physical examination was within normal limits.

The hemogram was normal, the blood urea nitrogen was 22 mg. per 100 ml. and the fasting blood sugar was 105 mg. per 100 ml. on admission. Marked pyuria and bacteruria without albuminuria

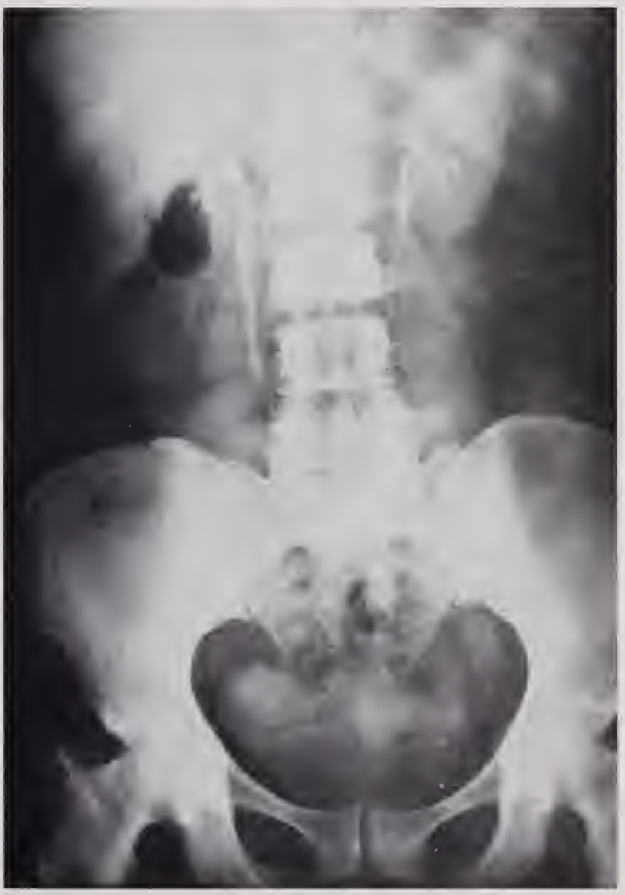

Figure 1. Minimal caliectasis is noted in the upper pole of the left kidney on the intravenous pyelogram taken forty-five months prior to admission.

The authors are both associated with Providence Hospital, 16001 W. Nine Mile, Southfield, Michigan; Doctor McQuiggan with the Department of Urology, and Doctor Liu with the Department of Pathology.

were noted on the urinalysis. Urine culture from the bladder and left kidney grew out Proteus. The 24 hour urine for acid fast bacteria and the tuberculin skin test were negative. Urine cytology was negative. Postoperative cholesterol was 209 mg. per 100 ml. and total serum lipid was 2638 mg. per 100 ml.

Since this patient presented with persistent urinary tract infection and non-visualization of the left kidney, retrograde studies were planned. At cystoscopy on December 21, 1967 some inflammatory changes on the floor of the bladder were seen. When the ureteral catheter was passed on the left side a thick purulent drainage was obtained. The retrograde pyelogram (**Figure 2**) demonstrated far advanced destructive inflammatory changes of the entire kidney with ragged edges and dilatation of the entire renal pelvis and ureter. The density of the third lumbar vertebrae was increased suggesting metastatic disease or Paget's disease of bone.

Since metastatic neoplasm was suspected as a cause of the vertebral lesion, a thorough search for a primary was undertaken. Upper gastrointestinal examination, barium enema, examination of the breasts and pelvic examination failed to demonstrate any neoplasms. The alkaline phosphatase was not elevated. Since none of these studies suggested neoplasm the diagnosis of Paget's disease of bone was made.

Because the left kidney was almost completely destroyed, funtionless, and involved with a severe purulent inflammatory process, a left nephrectomy was advised. On December 27, 1967 the left kidney was approached through the twelfth rib bed and left nephrectomy was performed. Postoperative course was uneventful. The urine culture was negative one week postoperatively. The patient was discharged on an ascorbic acid preparation and nitrofurantoin 100 mg. four times a day.

The kidney weighed 180 mg. Its capsule was thickened, edematous and firmly adherent to the renal cortex. On the cut surface (**Figure 3**) the renal calyces and pelvis showed marked dilatation and tissue destruction. The inner surface appeared ragged and hemorrhagic. In the adjacent renal tissue, numerous small bright yellow nodules and fibrotic areas were present. Microscopically, the wall of renal calyces and pelvis, and part of renal medulla were replaced by a thick band of granulation tissue which was characterized by numerous congested capillaries and rich cellular infiltrate of an inflammatory nature. Toward the calyceal surface, hemorrhage and tissue necrosis were marked. In the cellular infiltrate, plasma cells predominated. However, the most striking feature was the presence of the large mononuclear xanthomatous cells, with a vacuolated and finely reticular

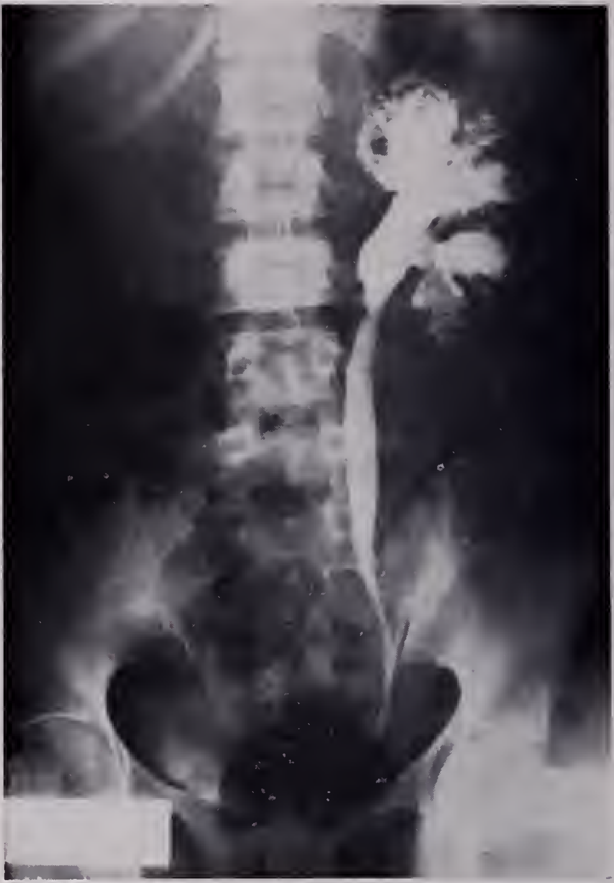

Figure 2. The preoperative left retrograde pyelogram demonstrates marked destruction of the entire kidney with dilatation of the entire ureter.

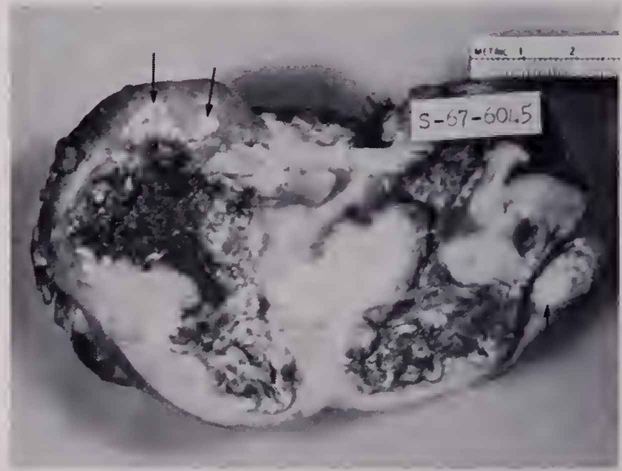

Figure 3. Cut surface of the bisected kidney showing marked destruction of renal tissue along the dilated calyces. Arrows indicate prominent yellow nodules of xanthomatous tissue.

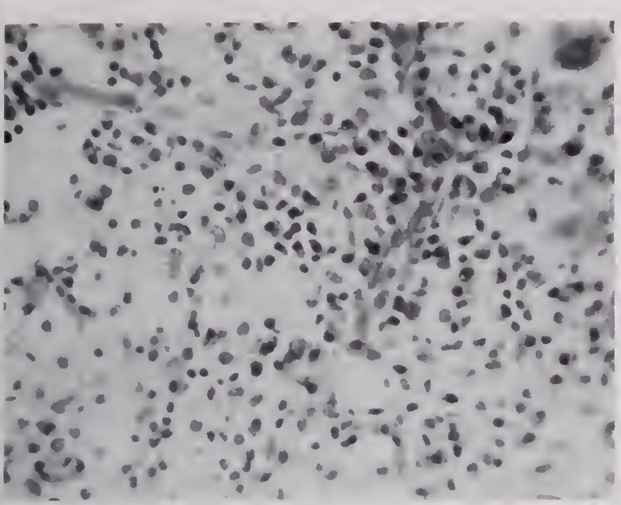

Figure 4. High magnification of an inflamed area. Note the intimate mixture of xanthomatous cells and other inflammatory elements. A multinucleated giant cell is in upper right (H and E stain, 450 X).

cytoplasm (**Figure 4**). Their nuclei were relatively small but often showed a prominent nucleolus. These xanthomatous cells were seen throughout the granulation tissue. Large aggregates of them corresponded to the yellow nodules seen grossly. Multinucleated giant cells with similar nuclear structures but with denser and more eosinophilic cytoplasm were frequently seen side by side with the xanthomatous cells. The renal cortical tissue displayed marked periglomerular and interstitial fibrosis with loss of parenchymal elements, leukocytic infiltration and exudates in the tubular lumen. The pathological diagnosis was xanthogranulomatous pyelonephritis.

Follow up lipid studies were obtained on June 17, 1968. They were as follows: Total cholesterol 289 mg. per 100 ml., total lipid 1000 mg. per 100 ml., triglycerides 67 mg. per 100 ml., Phospholipid 8.5 mg. per 100 ml. The lipoprotein electrophoretic pattern was normal with a 35 percent alpha fraction and a 65 percent beta fraction.

DISCUSSION

INCIDENCE

Xanthogranulomatous pyelonephritis is an unusual disease which is rarely bilateral.[12] The youngest reported case was in a nine year old girl[5] and the oldest reported case was in an eighty-two year old man.[6] The disease occurs most commonly in the fifth decade. The sex distribution varies with the series reported.[5, 6]

ETIOLOGY

At the present time it is not clear whether this xanthomatous process represents a localized response to infection or a generalized lipid disorder. Saeed and Fine in a report of four cases[7] incriminate a metabolic defect of lipid metabolism because of the absence of lipid macrophages in other types of pyelonephritis and the variable bacterial flora seen in xanthogranulomatous pyelonephritis. However, this was a speculative assumption since the serum lipid fractions were not studied. In our case a complete lipid profile was obtained (see case report). The total serum lipid and the total cholesterol were slightly elevated, but the phospholipid, the triglycerides and the lipoprotein electrophoretic pattern were within normal limits. This suggests that this disease is not a generalized lipid disorder but rather represents a peculiar localized reaction to infection in which phagocytosis of a fatty substance takes place. Diabetes mellitus is not associated with xanthogranulomatous pyelonephritis as it is with some of the other xanthomatous diseases.

All cases of this disease have severe bacterial infections of the kidney and the majority of these infections involve a Proteus organism. Renal calculi often accompany infections caused by urea splitting organisms such as Proteus, so their presence in xanthogranulomatous pyelonephritis is not surprising. Many of the cases reported are associated with obstructive uropathy. While this may initiate the infection it would not be a specific cause of this disease.

CLINICAL COURSE

Typically the patient with xanthogranulomatous pyelonephritis presents with a history of recurrent urinary tract infection, Proteus being the most common organism involved. Often the urine cannot be cleared with antibiotic therapy. Symptoms include those of bladder irritation and hematuria as well as generalized sepsis with chills and fever. Flank pain is common. Occasionally this disease presents as an abdominal mass.[8] The disease process is destructive and usually the involved kidney is completely functionless. Fortunately the disease is almost always unilateral and therefore nephrectomy provides a complete cure. The natural course of the disease has not been previously documented and this case is unique in this respect. Minimal pyelonephritic changes progressed to complete destruction of the kidney within a four year period.

DIAGNOSIS

This disease is unique in that it may mimic renal neoplasm radiographically, grossly and even microscopically. The affected side is usually not visualized by intravenous pyelography because of the lack of function. The retrograde pyelogram may demonstrate a space occupying lesion as seen in a hypernephroma. Or it may present as a diffuse inflammatory process involving the entire kidney with or without hydronephrosis and hydroureter, as is seen in renal tuberculosis or some types of far advanced obstructive uropathy. Angiography, if done, usually demonstrates a decreased vascular pattern which may be of some help in the differential diagnosis.

At operation the diagnosis is not always obvious. At times the diseased kidney is adherent to adjacent structures as seen in neoplasm and unnecessarily radical operations have been performed. In one case, what was thought to be an inoperable hypernephroma was biopsied and the microscopic diagnosis of clear cell hypernephroma was made. Radiation therapy was given. When the patient was alive nine years after the initial diagnosis the slides were reviewed and the error was discovered.[8] The lesion which was thought to be hypernephroma was indeed xanthogranulomatous pyelonephritis.

PATHOLOGY

The definitive diagnosis of xanthogranulomatous pyelonephritis can be made only by histologic examination of the diseased kidney. Grossly the xanthomatous area is bright yellow and if localized may appear neoplastic. However, if diffuse it resembles a severe pyelonephritis with or without pyonephrosis and small renal abscesses. Microscopically an intimate admixture of large, vacuolated, mononuclear xanthomatous cells and abundant inflammatory infiltrate is seen in xanthogranulomatous pyelonephritis. In renal cell carcinoma of the clear cell type the individual cells may resemble the xanthomatous cells, but the neoplastic cells are arranged in an organoid pattern with less inflammatory infiltrate. The PAS positive material is usually negative after diastase treatment in renal cell carcinoma but remains positive in xanthogranulomatous pyelonephritis. Fat stains demonstrate abundant lipids in xanthoma cells. Confusion in diagnosis is usually encountered when only a limited portion of the kidney is available.

TREATMENT

Since the disease process is usually so far advanced when the diagnosis is made, antibiotic therapy has little value in the primary treatment of xanthogranulomatous pyelonephritis. Fortunately the disease is usually unilateral and nephrectomy provides a complete cure. In the few cases in which pyelonephritis has been noted in the contralateral kidney an attempt should be made to sterilize the urine and keep the kidney free of calculi.[6] In our case minimal caliectasis was noted in the remaining kidney and the patient was placed on nitrofurantoin indefinitely. Ascorbic acid was added to the regimen to acidify the urine and thereby potentiate its effect.[4] The urine has remained sterile to date.

SUMMARY

A case of xanthogranulomatous pyelonephritis in a fifty-five year old female is presented. The case is unique because the progression of the disease from minimal caliectasis to complete renal destruction during a four year period is documented. An essentially normal serum lipid profile suggests that this disease represents an unusual reaction to infection rather than a generalized disease.

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Physicians - Population Ratios in Michigan - 1968

County	Population	M.D.'s	D.O.'s	People per Physician
Alcona	6,000	0	0	—
Alger	8,400	5	0	1,680
Allegan	56,500	27	2	1,948
Alpena	30,000	28	1	1,035
Antrim	9,000	3	5	1,125
Arenac	9,000	3	1	2,250
Baraga	7,200	4	0	1,800
Barry	30,000	15	4	1,579
Bay	107,000	91	28	899
Benzie	7,800	3	2	1,560
Berrien	161,000	112	25	1,175
Branch	34,000	29	4	1,030
Calhoun	151,000	146	36	829
Cass	36,500	10	3	2,830
Charlevoix	15,500	7	1	1,938
Cheboygan	14,000	8	0	1,750
Chippewa	35,000	20	3	1,521
Clare	12,000	6	6	1,000
Clinton	43,000	11	6	2,529
Crawford	5,200	8	1	578
Delta	34,000	23	0	1,478
Dickinson	23,600	28	0	843
Eaton	55,000	22	9	1,774
Emmet	16,500	42	1	384
Genesee	435,000	331	151	895
Gladwin	10,000	4	4	1,250
Gogebic	20,000	13	1	1,429
Grand Traverse	36,000	82	18	360
Gratiot	38,000	22	13	1,086
Hillsdale	34,000	17	6	1,478
Houghton	34,000	26	0	1,308
Huron	34,000	20	5	1,360
Ingham	265,000	296	63	710
Ionia	44,000	22	11	1,333
Iosco	20,000	5	1	3,333
Iron	15,000	11	2	1,154
Isabella	36,000	29	7	1,000
Jackson	135,000	110	22	1,022
Kalamazoo	190,000	242	13	745
Kalkaska	4,500	3	0	1,500
Kent	385,000	440	84	735
Lake	4,500	3	1	1,125
Lapeer	46,000	24	19	1,070
Leelanau	9,500	1	1	4,750
Lenawee	78,000	60	6	1,181
Livingston	42,000	27	9	1,166
Luce	7,500	14	0	536
Mackinac	10,800	6	3	1,200
Macomb	575,000	238	161	1,441
Manistee	19,200	15	6	914
Marquette	63,500	56	0	1,134
Mason	21,500	17	1	1,194
Mecosta	21,500	13	6	1,132
Menominee	25,000	10	0	2,500
Midland	55,000	60	2	887
Missaukee	6,000	2	0	3,000
Monroe	110,000	43	17	1,833
Montcalm	37,500	19	25	852
Montmorency	4,200	0	1	4,200
Muskegon	150,000	122	45	898
Newaygo	25,000	13	1	1,786
Oakland	900,000	992	300	696
Oceana	16,000	6	1	2,286
Ogemaw	9,000	8	3	818
Ontonagon	11,000	4	0	2,750
Osceola	13,800	4	3	1,971
Oscoda	3,500	1	1	1,750
Otsego	8,500	7	0	1,214
Ottawa	106,000	75	9	1,262
Presque Isle	12,500	3	0	4,167
Roscommon	7,300	6	4	730
Saginaw	208,000	175	62	878
St. Clair	110,000	80	10	1,222
St. Joseph	43,000	28	5	1,303
Sanilac	34,000	17	8	1,360
Schoolcraft	8,000	6	0	1,333
Shiawassee	59,000	32	7	1,512
Tuscola	45,000	17	10	1,667
Van Buren	51,000	27	2	1,762
Washtenaw	210,000	756	17	271
Wayne	2,670,000	3,049	651	721
Wexford	18,000	18	4	818

These figures from Michigan Health Council

MAP . . . A Decade of Accomplishment

What is?

What if?

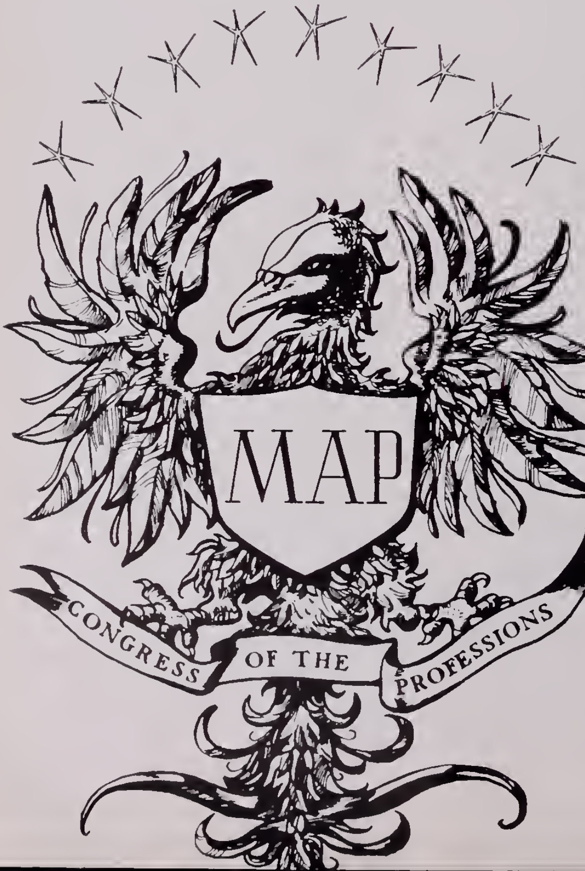
Together those two thoughts form a synthesis for action.

As questions they demand answers. As musings they spark imaginative hopes. As challenges they issue a clarion call to accomplishment. They resulted in the organization of MAP ten years ago.

In 1957 the medical profession said, by way of a survey conducted by the MSMS, that it believed coordinated activity of the professions was overdue.

THE SURVEY SPELLED out the major needs — the "what is" — and the favored procedures for meeting those needs in an organization devoted to the protection and promotion of professionalism — the "what ifs."

Hugh W. Brenneman, then Public Relations Counsel of MSMS and adviser to a number of other state professional associations, was authorized to proceed with the organization of an association of the professions and money was advanced to hire staff assistance and pay for initial meetings and mailings.



Coincidental with this action by the medical society, other professional societies were alerted to the potential of united action by the leading professions in areas of education, legislation, professional and public relations, and business services.

Almost simultaneously the boards of directors of the state professional societies passed resolutions calling for the establishment of a permanent organization with individual memberships as well as state association representation which could become financially viable and independent of any single group.

Their thinking was summed up in the expression of George W. Slagle, M.D., the then President of the MSMS.

"The power of the professions, as organizations, to serve the public good is not being used effectively because it is not being exerted in unison," Dr. Slagle said. It is ironic that at a time in our history when the nation is crying for brain-power, the most learned group of all, the professions, are being by-passed when decisions affecting their future are being made."

His successor, G. B. Saltonstall, M.D., supplemented his thought with: "Industry and labor are represented at the bargaining tables of the nation by single, powerful voices, backed by separate organizations which represent segments of interest. Legislators consult — and listen to — the wishes and demands of these highly organized groups (industry - labor). Their opinions are sought on almost all matters of legislation. By contrast, the professions are rarely considered, much less consulted, except in those instances when the matter directly affects technical subjects within the purview of one particular profession."

PEOPLE AND GROUPS at interest, but outside of the professional policy-making boards, were also consulted. Lester P. Dodd, J.D., Detroit attorney, a Past President of the State Bar and Legal Counsel of the MSMS, drafted bylaws. Dr. Marvin Niehuss, Vice President and Dean of Faculty of the University of Michigan lent support and advice. Congressman Gerald R. Ford, Jr., encouraged the development, various association executives and businessmen indicated interest and Pat Loomis as the sole staff assistant worked overtime.

Leaders of the five Charter professions met and agreed to form an association so that all professions might work together for their mutual benefit. Delegates appointed by the Board of Directors of the individual state professional societies worked out the organizational details, by-laws, administrative lines, membership qualifications, etc. The state professional societies represented at these meetings included the Michigan Society of Architects, the Michigan Society of Professional Engineers, the Michigan State Dental Association, the Michigan State Medical Society and the State Bar of Michigan.

The final organizational meeting, following approval in principle of a projected set of by-laws by the state professional societies, was held on November 23, 1958, in the new board room of the Michigan Road Builders Association in Lansing.

Bylaws were adopted, a board of directors and officers were elected and authorization given for incorporation papers to be filed.

The Founding Board members were as follows:

William M. LeFevre, M.D., President
Floyd D. Ostrander, D.D.S., Vice President
Elmer J. Manson, A.I.A., Secretary
Frederick Von Voigtlander, P.E., Treasurer
Hugh W. Brenneman, Executive Director
John G. Nolen, D.D.S.
G. B. Saltonstall, M.D.
N. O. Saulter, P.E.

THE MICHIGAN ASSOCIATION of the Professions was officially incorporated on December, 1, 1958.

Growth was inevitable. Individual membership climbed quickly — first one, then two, then three thousand; the number stabilized at 3,000. State organization membership applications were received and after studied deliberations, new professions were added — certified public accountancy, veterinary medicine, pharmacy and education. Approximately 100,000 professional people are members of MAP state organizations. Still other professions are being considered.

Other states heard the story, first New York, then North Carolina, Illinois, Virginia, Wisconsin, Pennsylvania followed the MAP pattern. Other states, Iowa, Nevada, Hawaii, Indiana, Florida, Texas, Louisiana, etc. are thinking, talking, evaluating, meeting — in order that they, too, can follow suit.

MAP is governed by a Board of Directors. On that Board recognition rather than control is accorded those professions having larger numbers of individual members. MAP by-laws provide that the Board of Directors of each State Organization Member designate two of its members, who are also members of MAP, to serve as Directors on the MAP Board. In addition to those thus provided, an equal number of Directors are elected at the MAP Annual Meeting from its individual membership. Of these not more than three, nor fewer than one, can be members of any one of the professions.

The purpose of MAP is "to devise ways and means of better utilizing the professional heritage of knowledge and skill for the benefit of society, and to create relations between the professions

Officials of MSMS who met with leaders of other professions to discuss organization plans for MAP were, left to right, G. B. Saltonstall, M.D., Charlevoix; George W. Slagle, M.D., Battle Creek; and William M. LeFevre, M.D., Muskegon.

MAP — A DECADE OF ACCOMPLISHMENT . . . CONTINUED

looking toward that end." MAP was created to provide the organizational machinery whereby the combined strength and counsel of all professions could be utilized for the advancement of professional ideals and the promotion of professional welfare. It is directed toward strengthening the traditional rights and privileges of each profession and, at the same time assisting the professions to better serve the people.

MAP-TYPE ORGANIZATIONS are designed to protect and promote professionalism. They do this via action *against* legislation which would permit third party control from whatever source — labor, business, government, farming or industry — over the professions. They *support* legislation which serves to encourage private practice and maintain the professional attributes of professional persons in employed practice. The *Legislative Report,* containing information on all bills of interest to the MAP professions is distributed weekly to all members wishing it. An annual trip to Washington keeps MAP in close contact with Michigan Congressmen.

Leader

Brink

Brenneman

LEADER — Luther R. Leader, M.D., Royal Oak, has served as a member of the MAP Board for four terms and has received the MAP Booster Award in 1963. Doctor Leader, a past president of MSMS, is now secretary of the State Board of Registration in Medicine.

BRINK — J. Russell Brink, M.D., Grand Rapids, is a member of the MAP Board of Directors, second term, and has been active in organizing the American Association of the Professions.

BRENNEMAN — Hugh W. Brenneman, executive director of MSMS and MAP, spearheaded the organization of the professional group and has served since its founding as its executive.

MAP Education Committees stimulate student interest in professional careers as well as advise secondary schools on curricula development.

Use is made of all communication media to tell the public why professional people do what they do in the way that they do it and why that way is in the public interest. Over a period of nine consecutive years, MAP has produced more than 500 quarter and half-hour telecasts over major commercial TV stations on prime time.

MAP activities in communication develop understandings and knowledge about the professions among the several professions by way of interprofessional meetings (the annual one is called the Congress of the Professions) and by MONITOR, The Journal of the Professions.

Business services designed to aid individual professional people to obtain savings through group purchasing, such as Group Term Accidental Death, Life, and High Level Life Insurance, Professional Liability Insurance can be maintained when several professions are together which many individual professions or professional persons could not otherwise obtain. The MAP Pension Plan and Trust, the first plan in the nation to qualify under the Keogh Act, has since been updated and stands today as a model plan in the nation.

MAP and its emerging national body, the American Association of the Professions, represent the professional segment of society to balance representation of other segments of society represented by such organizations as NAM for industry, US Chamber of Commerce for business, AFL-CIO for labor, Farm Bureau for farming.

Is it not necessary that one organization be able to present basic thinking of the professional segment of society as these organizations do for their segments? Otherwise how are the wishes of the professions as minority groups going to be put forward?

THE AMERICAN ASSOCIATION of the Professions has been formed with the following purposes:

1. The encouragement of participation, throughout the United States, of all the professions in programs having for their objectives the advancement of professional ideals and professional welfare.

2. The promotion of better understanding between and among the several professions.

3. The promotion of a free and cordial interchange of opinion and information among its

MAP'S FOUNDING BOARD — These men comprised the first Board. Seated left to right are F. Von Voigtlander, P.E., Ann Arbor; William M. LeFevre, M.D., Muskegon; F. D. Ostrander, D.D.S., Ann Arbor; Elmer J. Manson, A.I.A., Lansing. Standing left to right are N. O. Saulter, P.E., Detroit; G. B. Saltonstall, M.D., Charlevoix; John G. Nolen, D.D.S., Lansing, Hugh W. Brenneman, Executive Director.

members on subjects of mutual or common professional interest.

4. The promotion, upon a national basis, of closer contact between and among the leaders of the learned professions.

5. The fostering, throughout the several states, of ever higher standards of professional ethics and conduct.

6. The promotion of programs and measures designed to protect the public and the professions against encroachments on professional practice by those not qualified.

7. The promotion of programs designed to offer professional and pre-professional students more adequate preparation for professional life.

8. The promotion of programs and measures designed to assist young professionals in meeting the problems of their respective professions.

9. The stimulation and fostering of leadership by the professions in public service activities on community, state and national levels.

FEW PROFESSIONAL PEOPLE can obtain more from any organization, other than their own primary professional society, than they can from MAP. Michigan is proud to be the front runner in this vital movement.

MAP has placed the professions "in the mainstream" of community and state-wide planning by working officially with civic groups in such activities as Michigan Week, Community Health Week and its own Professional Week which has been proclaimed for eight successive years by Michigan's governors.

If an organization is known by the "company it keeps" MAP must certainly rank at the top. Among those receiving its highest Awards were such leaders as famous architect Minoru Yamasaki (1963), Chief Justice John R. Dethmers (1964), State Building Director Adrian N. Langius (1965), Explorer Talbert Abrams (1966), Sculptor Marshall Fredericks (1967), and Dental Leader Dr. John G. Nolen (1968) — all of whom received the MAP Distinguished Award for Professional Excellence.

Outstanding Service Awardees, named for their contributions to the professions, were: Lester P. Dodd (1963), Hugh W. Brenneman (1964), Gerald R. Ford, Jr. (1965), Emory W. Morris (1966), Harlan Hatcher (1967), Harold F. Gross (1968).

BEGINNING DECEMBER 1, 1968, MAP will celebrate its 10th Anniversary. Many major activities are being planned, highlighted by a trip to Spain on February 8th and the final formal structuring of the American Association of the Professions.

MAP enters its second decade with a proud record of accomplishment, successfully organized and financed. At one of the early meetings, following the successful organization of MAP, Hugh Brenneman was officially declared to be Founder of the association and a motion of thanks to him was passed. Noting a moist eye, President LeFevre said to him: "This means a lot to you doesn't it?" The reply: "Yes. And I hope it means a lot to the professional people of Michigan."

Most "head colds" last 7 to 14 days
18
WEDNESDAY
TUESDAY

In the meantime...Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

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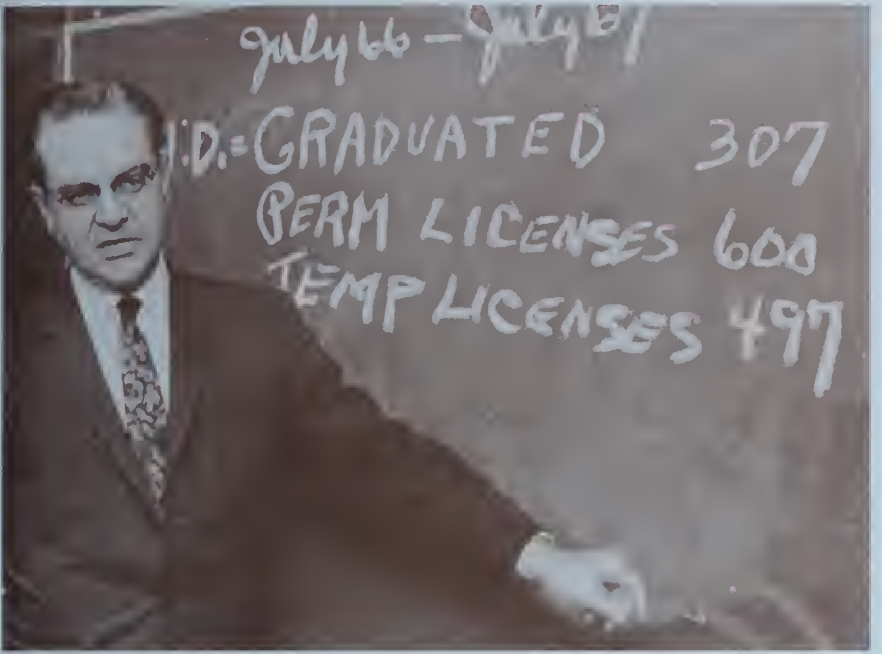
MSMS Manpower Plea Picks Up Speed



MSMS Council Chairman Ross V. Taylor, M.D., at a news conference in Jackson stressed that Michigan graduates about 300 doctors each year and licenses 1,000-1,100 physicians each year as a debtor state. (Jackson Citizen-Patriot Photo)

Co-Chairmen Robert J. Mason, M.D., left, MSMS President-Elect, and Warren Huff, outstanding Michigan educator and civic leader, spoke at the MSMS Medical Manpower Conference at Saginaw November 21 to 75 physicians and decision-makers from central Michigan and Thumb area.

All across Michigan the MSMS appeal that more physicians must be trained in Michigan is getting enthusiastic support from businessmen, civic leaders, industrialists, labor officials, educators, professional men, and the mass media.

The challenge that MSMS step up its efforts to stress the need for more medical schools was adopted by the 1968 MSMS House of Delegates. The organizational meeting for the Michigan Citizens Committee on Medical Education was organized in Detroit October 16, followed by a Michigan Conference on Medical Manpower at Battle Creek October 23. The MSMS Council outlined both immediate and long-range recommendations November 6 in a letter to the State Board of Education.

The first MSMS-sponsored regional conference, in connection with county society leadership workshops, was held in Grand Rapids November 14, and the next in Saginaw, November 28. The third is scheduled for the Metropolitan area December 12.

TV and radio stations have told the stories and articles have appeared in newspapers in Detroit, Lansing and across the state.

The MSMS appeal for more physicians was presented at Grand Rapids November 14 to, 100 physicians and community leaders from western Michigan by MSMS Secretary Kenneth H. Johnson, M.D.

Members of a special MSMS committee appointed to recommend courses of action for county medical societies to follow regarding health planning councils met recently with two invited guests. In photo at right, Mrs. Betty Tableman, executive director, Comprehensive State Health Planning Commission, visits informally with, left to right, MSMS Councilor Sidney Adler, M.D., Detroit; George T. Kelleher, M.D., Battle Creek; and MSMS Councilor John R. Pedden, M.D., Grand Rapids. In photo at left, Edwin S. Marsh, third from left, director, Health Planning Council of Michigan, talks during the dinner break with, left to right, MSMS Councilor A. C. Stander, M.D., Saginaw; MSMS Councilor Ralph R. Cooper, M.D., Detroit, and D. Bonta Hiscoe, M.D., Lansing. Otto K. Engelke, M.D., Ann Arbor, another member of the committee, was unable to attend.

Committee at Work to Develop Recommendations To County Societies re Planning Councils

At the September, 1968 meeting of The Council an ad hoc committee was authorized "To study recommended courses of action for component medical societies re health planning councils."

The special committee was a result of an action of the 1968 House of Delegates in adopting Resolution 3 "That the county societies be made cognizant of the role which can be played by them in taking leadership in the regional councils of the State Comprehensive Health Planning Commission."

Members at this first meeting received an in-depth review of the statutory requirements of this program from Mrs. Betty Tableman, Executive Director of the Comprehensive State Health Planning Commission. Mr. Edwin S. Marsh, Director of the Health Planning Council of Michigan, reviewed the voluntary role that can be made in comprehensive health planning on a regional basis.

A report of the initial committee meeting will be received by The MSMS Council at its meeting December 18.

WSU Thyroid Program Lists Top Speaker

Sidney Ingbar, M.D., Boston, and Joseph Matovinovic, M.D., Ann Arbor, will be among the principal speakers at the Eighth Annual Wayne State University Thyroid Workshop, December 11. The program will be held at the Wayne County Medical Society auditorium.

Doctor Ingbar will discuss pharmacology of iodine and Doctor Matovinovic will trace the history of goiter.

Interested physicians may obtain copies of the complete workshop program from WSU medical school or Joel I. Hamburger, M.D., 20905 Greenfield, Southfield 48075.

SECOND MARGOLIS FILM OUT NOW ON SEX, TEENAGER

The premiere showing of "Sexuality and the Teenager," a new film produced by Doctor and Mrs. Frederick Margolis of Kalamazoo, was held recently at Western Michigan University.

Included in the program was a panel discussion featuring Tommy N. Evans, M.D., Chairman and Professor of the Department of Obstetrics and Gynecology, WSU; Stuart Finch, M.D., Professor of Psychiatry and Head of the Children's Psychiatric Hospital, U-M; Pauline Iyenaga, M.P.H., Family Life Education Consultant with the Bureau of Maternal and Child Health, MDPH; and Doctor Margolis.

This film is a sequel to the Doctor Margolis' popular film "Parent to Child About Sex."

MAP Invites MSMS Members Join Special AAP Tour to Spain

The Inauguratory Session of the American Association of the Professions will convene in Detroit on February 22, 1969, recess, and reconvene in Malaga, Spain, on February 23, 1969.

As the opening major event of its 10th Anniversary Year, MAP, in cooperation with seven other State Associations of the Professions, will formally launch the American Association of the Professions and concomitantly sponsor a trip to Spain.

This trip, in behalf of the originators of the national body, members of MAP and of its components — also includes the Michigan State Medical Society.

All members of MSMS are invited to make the trip and take their families with them, each at the attractive rate of $359. This includes eight days room and board at the Hotel Pepe, taxes and tips, the plane trip (DC-8-61F) to and from Spain, the meeting, reception and dinner which precedes enplaning. The flight from Spain will return March 2.

The AAP has been organized for several years but has never been structured and implemented, awaiting the development of several State Associations of the Professions — which has now been completed. The proposals up for adoption at the February 22 meeting will be those put forth at the preliminary national get-together at Harbor Springs in the summer of 1967.

MAP spokesmen point out that: "Hotel Don Pepe and Malaga are on the sunshine coast of Spain where, even during the coldest months, temperatures rarely dip below 60 degrees and more often than not, it is sunny and warm.

"By contrasting picturesque whitewashed villages, with some of the world's finest hotels, nightclubs and luxury apartments, this birthplace of Pablo Picasso harmonizes new resort living with ancient customs and traditions.

"On any winter's day, it is possible to ski on fresh snow in the Sierras during the morning, play a round of golf or a set of tennis by the sea, have a siesta on the beach in the afternoon, and pass an enjoyable evening in one of those typical Spanish bodegas.

"The non-athletes, who can forego lazying on the beach or swimming in the pools (the hotel has three of 'em) can take inexpensive side trips to Granada ($12), Tangier-North Africa ($35—by air), Gibraltar, etc."

MSMS members wanting more information may write or phone:

Michigan Association of the Professions
120 West Saginaw
East Lansing, Michigan 48823
Area Code 517 — 337-1725

WSU Symposium on Blood Jan. 17-18

Wayne State University's 17th Annual Symposium on Blood has been scheduled for January 17 and 18 at the McGregor Memorial Conference Center.

The theme will be "Disseminated Intravascular Coagulation." Sessions on the second day will be devoted to open topics in the area of hemostasis.

Committee members are Dr. Eberhard F. Mammen, Dr. Gordon F. Anderson, and Dr. Marion I. Barnhart, professor, all in the Department of Physiology and Pharmacology at WSU.

APPLICATION FORM — detach and mail to:

CRAVEN TOURS, INC.
202 M.A.C. Avenue
East Lansing, Michigan 48823
Tel: (517) 351-9210

Make checks payable to: Michigan Association of the Professions

PS/13

Name____

Address____
(street)

____
(city, state and zip code)

I/we wish to PLANE TO SPAIN with the American Association of the Professions and enclose a deposit in the amount of $100.00 per person (total deposit enclosed $________)
I will be accompanied by: (give full names and relationship of all persons for whom deposit is enclosed)

____

I require a single room ☐ (Supplement $35.00)

I promise to pay the balance of $259.00 per person not later than January 21, 1969.
I have read and understand the terms and conditions of the trip, and agree to them.

Signed____________________________Date______________

Doctor Loupee Dies; Served In Legislature

Sherman L. Loupee, M.D., 96 years old, who served in the State Legislature from 1939 to 1949 and who was selected by MSMS as "Physician-of-the-Year" in 1952, died October 31 in Dowagiac where he had practiced many years.

Doctor Loupee, who underwent surgery last year, was last honored by MSMS at its special Government Day during the MSMS Centennial observance in Detroit in 1965.

A former delegate for many years to both the state and national Republican conventions, Doctor Loupee had a long list of civic accomplishments. He was mayor of Dowagiac in the 1950's and for a time was a member of the Dowagiac Board of Education. He was long active in the Dowagiac Chamber of Commerce and Rotary Club.

Born September 4, 1872, he attended Eastern Michigan University and taught in the Dowagiac area before entering the old Illinois College of Physicians and Surgeons which later became a part of the University of Illinois Medical School. He was graduated in 1904 and began practice in Vandalia in 1904, moving to Dowagiac in 1919. While in Vandalia, he served as village president and school board president.

Several years ago, he was joined in practice by his son, George.

HARPER APPOINTS CHIEF OF STAFF

Sidney Miller, M.D., who has practiced 21 years in the Birmingham-Detroit area, has been appointed full-time chief of staff of Harper Hospital. He began duties December 1 at Harper, where he did his internship and residency.

Gerber Products Company has made an unrestricted teaching and research grant to the Department of Human Development, College of Human Medicine, Michigan State University. Left to right: Dr. R. A. Stewart, Director of Research at Gerber; William B. Weil, M.D., Chairman of the Department of Human Development.

Hunt to Lead Comprehensive Health Council

Six Michigan physicians are among the 32 citizens named by Governor Romney to serve as the Michigan Advisory Council on Comprehensive Health Planning.

Andrew Hunt, Jr., M.D., Dean of the MSU College of Human Medicine, has been named chairman of the Council.

Physicians named to the Council for one-year terms expiring Oct. 24, 1969, are: Vernon V. Bass, M.D., of Saginaw; James Hagans, M.D., of Kalamazoo; and Julian Priver, M.D., of Detroit.

Winston B. Prothro, M.D., of Grand Rapids, and Herbert A. Raskin, M.D., of Detroit, were named to two-year terms ending Oct. 24, 1970; and Myron E. Wegman, M.D., of Ann Arbor, will serve a three-year term expiring Oct. 24, 1971.

Keast Appeals For More Med School Faculty

Wayne State University's School of Medicine must continue to build its faculty if it is to double present student enrollment by the time new facilities are completed, President William R. Keast told the WSU Board of Governors recently. Mr. Keast emphasized that the need for doctors, nurses, hospital pharmacists and related medical technicians "was never greater."

He pointed out that the 1969-70 operating budget request of $49.26 million was needed if WSU was to carry out its educational responsibilities. The budget, approved by the board, represents an increase of $11.09 million over the current State of Michigan appropriation of $38.18 million. Student fees and other revenue total $15.13 million, bringing the total budget to $64.39 million for next fiscal year.

Mr. Keast said a major part o the budget increase represent funds which will permit Wayn State to fill its unique role i making a much needed impac upon urban problems facing Detroit and the nation.

Zoccolillo Heads Dow Life Sciences

Roger R. Zoccolillo was appointed assistant general manage of Dow Life Sciences, the Do Chemical Company's worldwid pharmaceutical and human healt business. In his new position, Mr Zoccolillo will participate in th general management of the activi ties of Pitman-Moore Medica Company, Diagnostic Products Bio-Science Laboratories, Lepeti S.p.A. and LIFE.

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Spinal Anesthesia in Obstetrics

Safe dose of spinal anesthetic drugs used for the obstetrical patient at term in well established labor. (Primipara – 8 to 9 cm.
Multipara – 6 to 7 cm.)

For Vaginal delivery: (Saddle Block)
- Procaine hydrochloride (Novocaine):
  30 to 50 mg. with or without dextrose.
- Tetracaine hydrochloride (Pontocaine):
  2 to 5 mg. with 5% dextrose.
- Dibucaine hydrochloride (Nupercaine):
  2.5 to 3.75 mg. with 5% dextrose.

For Cesarean Section:
- Tetracaine hydrochloride (Pontocaine):
  5, 6, 7 or 8 mg. with dextrose.
- Dibucaine hydrochloride (Nupercaine):
  3.75 mg. to 5 mg. with 5% dextrose.
- Procaine hydrochloride (Novocaine):
  50 to 75 mg. with or without dextrose.

For safe management of spinal anesthesia in the Obstetrical patient:

1. Start intravenous fluids before giving spinal anesthesia with 18 or 19G needle, or 18G plastic cannula.
2. Take blood pressure, pulse, and respiration before giving spinal anesthesia.
3. Inject spinal anesthetic drug after a contraction – never during a contraction.
4. Keep patient's head elevated with pillow when patient is placed supine after giving spinal anesthesia.
5. Take blood pressure, pulse and respiration q 2 min. for first 10 min. after spinal anesthesia has been given, then q 5 min. for next 20 min.
6. Watch sensory anesthesia level for first 20 min. after giving spinal anesthesia.
7. Always have vasopressor drug (ephedrine, etc.) readily available to give intravenously, if necessary, during spinal anesthesia.
8. Always have a bag and mask, and oxygen available so that oxygen can be given by intermittent positive pressure if patient develops respiratory difficulty.
9. Always have the patient in the delivery room and keep patient in the delivery room when spinal anesthesia is given.
10. Always use careful aseptic technique in giving spinal anesthesia – be sure the drugs used have been autoclaved – (not cold sterilized).

NOTE: Use individual small ampules. **DO NOT** use stock bottle solutions.

11-1-68

MATERNAL HEALTH DESK REFERENCE CARD NO. 2

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Septic Abortion, With or Without Septic Shock: Diagnosis and Treatment

Cases of threatened or incomplete abortion, with or without associated septic shock, are a major problem in the current medical scene in Michigan. The history is usually one of cramps in the lower midline of the woman's abdomen, the passage of blood and clots, and tissue, in some cases from her vagina. She may have had feverishness and chills for the past 1 or 2 days. Some will admit to being 2 to 6 weeks overdue on the menses. All cases of septic abortion are best considered as being due to instrumentation of the uterus until demonstrated to be otherwise.

The findings on physical examination may be: temperature of from 96.8 to 105 F., subnormal levels indicating presence of severe infection and shock. Initial normal temperature does not preclude presence of a potentially severe and dangerous sepsis. Temperature, pulse and respiration rates should be recorded in all cases every 4 hours for the first few days so as not to fail to detect any initial wide swings, if and when they occur, these signal a dangerous degree of infection and must not be missed. Blood pressure may be normal or down to shock levels. Patient may not appear to be actually ill when first seen. Abdomen may evidence tenderness, rebound tenderness, even muscle rigidity. Uterus may be normal in size, or enlarged to size of 8 to 12 weeks of pregnancy, and may be intrinsically tender.

Sterile speculum examination may reveal bloody discharge from cervix canal; some clots and conceptual tissues may be present. Amount of discharge may vary from scant to profuse, may have foul odor. Cervix may be closed or open, firm or soft, normal in size or enlarged. There may be thickening, induration or tenderness of the bases of the broad ligaments. Tubes and ovaries may be normal and nontender, or enlarged, tender, prolapsed, and adherent to floor of lateral pelvic fornices.

Shock may be evidenced by blood pressures of 80/50, or lower, a pulse rate of 110, or higher, coolness and moisture of the extremities. Shock may be due to blood loss, to sepsis, or to a combination of blood loss and sepsis. Quickly determined white and red blood cell counts, and hemoglobin and hematocrit determinations, are of major aid in deciding the cause of shock. Shock most likely is not due to blood loss if patient's hemoglobin is 10 grams or higher, or hematocrit reading is 34 to 36 percent or higher. The venous pressure is the most reliable method of determining the need for intravenous fluids or blood transfusions. When shock thus is found not to be on basis of blood loss, it is most probably due to sepsis, in which event all major treatment efforts are best directed toward eradication of the infection. In such cases it is best not to give a blood transfusion, or more than a very slow drip maintenance volume of intravenous fluids, until such time as this can be accomplished without danger of overloading the cardiovascular system and possibly inducing decompensation. In cases of severe septic shock acidosis may be present, and blood pH determination should be made.

The following steps in treatment are given in time sequence of performance:

(1). Start 1,000 ml. bottle of 5 percent glucose in water intravenously; insert Foley catheter in bladder and connect for continuous drainage; start recordings on a fluid intake and output chart. At same time get blood samples for determination of potassium, sodium, chloride levels, the CO_2 percentage and pH values.

11-1-68

(2). Perform at once sterile speculum vaginal examination, obtaining material for culture from high in cervical canal, or uterine cavity, and have it planted as soon as possible for culture and sensitivity testing (if these culture specimens dry out or otherwise die before they are properly planted the most important and crucial guide to the best means of saving the woman's life may be lost).

(3). Next, adequate amounts of penicillin and chloramphenicol are added to the bottle of 5 percent glucose. If the woman is very ill, 6 to 20 million units of aqueous penicillin and 2 to 3 grams of i.v. chloramphenicol should be added, and they can run in as a slow drip over a period of 12 to 24 hours, and longer as necessary; 1 to 2 grams of streptomycin may also be injected intramuscularly. If the woman is not so ill, smaller doses intramuscularly and orally can be given.

(4). Lost blood should be replaced when and as indicated by initial and repeated blood cell counts, hematocrit determinations and as indicated by the venous pressure. If patient's hemoglobin is less than 10 grams, or hematocrit is less than 30 to 34 percent, a blood transfusion should be given right away, if indicated by the venous pressure. Always listen at intervals for the development of basal rales posteriorly, and cut down on the rate of intravenous flow of the blood or glucose solution, or stop them entirely, as need be, in order to prevent cardiac decompensation and pulmonary oedema. If a woman is still in shock after her hemoglobin has been brought up to 10.5 to 11 grams, no more blood should be given for the time being; an intravenous drip containing an antihypotension agent can be run in as slow as 20 drops per minute using the glucose solution. This will permit additional time for combatting her infection. Monitoring with Central Venous Pressure is an excellent aid in managing blood volume and fluid replacement.

(5). General supportive care includes the maintenance of fluid and electrolyte balance, administration of nasal oxygen is indicated, the provision for necessary periods of sleep, and the giving of reassurance.

(6). Dilation and curettage should usually be done about 24 hours after commencement of antibiotic and general therapy, regardless of her febrile state, unless such procedure probably would prove fatal; it may be performed sooner than 24 hours if there is too much uterine bleeding. This is best done with ovum ring forceps under paracervical block using 1 percent xylocaine; demerol analgesia may also be indicated.

(7). If shock is not relieved by administration of blood and/or intravenous fluids, and antibiotic agents, metarminol bitartrate (Aramine) may have to be administered by slow intravenous drip, the drug being added to a bottle of 5 percent glucose. Such therapy must be closely watched by a physician, who will take and record the blood pressure every 30 minutes or so, and will discontinue administration of the drug as soon as the blood pressure rises to levels just above the shock state. If this drug is not sufficiently potent in its effect, levarterenal bitartrate (Levophed) may be administered instead. After the drug has been discontinued, the pressure may fall again, and it will have to be administered again, but this is much better than using it continually over too long a period.

(8). Corticosteriod therapy may be indicated in a few cases, and one of the available suitable products may be given intramuscularly or intravenously. The intravenous administration of 7½% sodium bicarbonate solution is indicated only if acidosis is present. It should be given not faster than 50 ccs in 20 minutes, and 50-100 ccs is usually an adequate dosage until a repeat blood pH determination can be made."

N.B. It is important to point out that the above therapy routine in general is also suitable in cases of regular puerperal sepsis. Also, if the infection is due to the gas bacillus, or to tetanus, then special therapy with antitoxin and antiserum is indicated; in fact some physicians give such injections in all cases of criminal abortion.

MATERNAL HEALTH DESK REFERENCE CARD NO. 3

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Use & Abuse of Oxytocics

Uterine rupture with resulting hemorrhagic shock (sometimes irreversible) and death of the mother as well as other unfavorable complications may result from injudicious use of oxytocics. The following Indications, Contraindications, and some possible dangers are presented as a guide to the use of this important group of drugs in obstetrics.

Some Indications for Oxytocics

1. INCOMPLETE ABORTION. To control uterine bleeding prior to surgical intervention or to complete the abortion without surgery.
2. SEPTIC OR MISSED ABORTION. To attempt emptying the uterus without surgical intervention.
3. HYDATIDIFORM MOLE. To stimulate the uterus to empty or during a molar abortion to hasten emptying or to control bleeding as with incomplete abortion.
4. ABRUPTIO PLACENTAE. After amniotomy if the cervix seems to promise early vaginal delivery.
5. POSTPARTUM UTERINE ATONY. Use oxytocics only after careful examination has ruled out retained placenta or laceration of the birth canal.
6. INDUCTION OF LABOR. For medical or obstetrical indications, such as:
    a. Diabetes mellitus
    b. Isoimmunization, Rh or other
    c. Dead fetus
    d. Toxemia — after the disease has been controlled for at least 12 to 24 hours
    e. Prolonged rupture of the bag of waters with the mother at or near term
    f. Suspected or proven amnionitis
7. UTERINE INERTIA IN UNOBSTRUCTED LABOR.
8. FOLLOWING DELIVERY BY CESAREAN SECTION.

Contraindications to Use of Oxytocics

The contraindications are as important as the indications, sometimes even more important. There is evidence that indicates measures other than oxytocics should be tried in the following conditions:

1. NORMALLY PROGRESSIVE LABOR. During the first or second stage.
2. PATIENTS WHO ARE POTENTIAL CANDIDATES FOR UTERINE RUPTURE
    a. Obstructed or possibly obstructed labor due to abnormalities of the bony pelvis or pelvic tumor,
    b. Malpresentations — abnormal vertex, transverse lie,
    c. Patients with previous cesarean section or myomectomy

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3. MULTIPARAE WITH FOUR OR MORE CHILDREN.
4. PATIENTS, 35 YEARS OF AGE OR OLDER.
5. PATIENTS WITH ALREADY OVERDISTENDED UTERUS. Such as
   a. Hydramnios
   b. Multiple pregnancy
   c. Fetus estimated to weigh over 9 pounds
6. PHYSICAL EXHAUSTION OF THE MOTHER.
7. PATIENT WITH UNENGAGED FETAL HEAD, ESPECIALLY IN PRIMIGRAVIDA.
8. WHERE WELFARE OF THE FETUS IS ALREADY IN DOUBT, indicated by
   a. Irregular heart rate,
   b. Heart rate persistently below 100 per minute, especially during a contraction
   c. Meconium-stained amniotic fluid in cephalic presentation

Administration of Oxytocics

In the use of oxytocics the following comments should be kept in mind.

EVERY PATIENT RECEIVING OXYTOCICS MUST HAVE SOMEONE, PREFERABLY A PHYSICIAN, OBSERVE THEM CLOSELY DURING THE FIRST 30 MINUTES LEST THE PATIENT HAVE A TETANIC CONTRACTION OF THE UTERUS OR DEVELOP A SEVERE HYPERTENSION.

1. PITOCIN Except after delivery of the placenta, intravenous infusion has replaced the intramuscular or subcutaneous administration of this drug.

   Five units (0.5 ml.) of the drug is placed in 500 ml. of 5% dextrose in water. The infusion is started at a rate of 8 to 12 drops per minute. Tetanic uterine contraction must be watched for and fetal heart tones checked frequently. If there is a tetanic uterine contraction or the fetal heart tones drop below 100 per minute, especially during a contraction, the infusion should be stopped immediately.

   During the first 30 minutes uterine contractions, fetal heart tones, blood pressure, and pulse are to be checked every 3 to 5 minutes. If significant abnormalities are found the infusion should be stopped and the situation carefully evaluated.

   After 45 to 60 minutes without any adverse effects the rate of flow may be increased up to 20 drops per minute if effective labor has not begun. Usually administration for 3 to 5 hours is sufficient for any one continued infusion.

2. SYNTOCIN This drug is given in the same dose, with the same technic, and with the same precautions as for Pitocin.

3. SPARTEINE SULPHATE (TOCASAMINE) The use of sparteine sulphate (Tocasamine) for the induction of labor or strengthening contractions cannot be recommended.

MATERNAL HEALTH DESK REFERENCE CARD NO. 4

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Suggested Standards of Prenatal Care

Good prenatal care significantly reduces maternal and perinatal mortality.

1. All pregnant women should have a complete history, and a general physical examination, including pelvic examination, with pelvic measurements and an evaluation of bony pelvic capacity, during the first trimester. Early examination is particularly important in high risk patients with major medical diseases and/or previous obstetrical complications.

2. Initial laboratory studies should include:
   - a) Urinalysis; glucose, albumin, and microscopic examination of a clean midstream specimen (to rule out asymptomatic bacteriuria).
   - b) Blood hemoglobin or hematocrit.
   - c) Determination of Blood type, and the presence of the Rh factor, with Rh antibody titers in Rh negative women.
   - d) A serological test for Syphilis.
   - e) A smear for presence of Gonococcus, when indicated.
   - f) A Papanicolaou smear from the cervix, where indicated by multiparity or age, or unless a smear has not been taken in over a year.
   - g) Additional tests may be indicated, e.g., glucose tolerance test, kidney function tests, blood chemistry, etc.

3. The patient's current status as to Polio and Tetanus immunizations should be determined, and where deficient, they should be immunized for both, according to the individual judgement of the physician.

4. Early consultation may be warranted when the course of a medical illness may affect or be altered by the pregnancy. Pregnant patients with heart disease, Diabetes Mellitus, or other medical complications, require close observation and supervision during the entire pregnancy and puerperium.

5. Weight gain of not more than 15-20 pounds is advised in normal patients. Diet should consist of 1800-2000 cal. daily, with about 80 Gm. protein, 200 Gm. carbohydrate, and 90 Gm. of fat. Reduction to 14-1500 cal. daily may be advised for obesity. Daily sodium requirements may be limited to 1 Gm. or less in the presence of edema, hypertension, diabetes, multiple pregnancy, or a history of previous toxemia. Multiple vitamin and iron supplements may be indicated. (Because of possible teratogenic effects, especially during the first twelve weeks, drugs administered should be clearly indicated.)

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6. Prenatal examination should be made at least monthly during the first 6 months, every 2 weeks during the 7th & 8th months, and weekly thereafter. More frequent examinations may be indicated in special situations, such as threatened toxemia, Diabetes, heart disease, multiple pregnancy, etc.

    a) Unless urgent, diagnostic radiography should be deferred until after the pregnancy.
    b) Urinalysis for albumin and glucose should be performed at each office visit. Significant bacteriuria should be treated even if asymptomatic.
    c) Weight, blood pressure, fundal measurement, fetal position, fetal heart tones, presence of edema, presence of abnormal vaginal discharge, should be checked at each prenatal visit.

7. At 28 weeks gestation, repeat hemoglobin or hematocrit, breast examination, and the determination of Rh antibody titer in Rh negative women, should be done.

8. With a history of mid-trimester premature labor repeated speculum exam (as often as once weekly) may be indicated for the detection of the incompetent cervix.

9. Hospitalization for investigation, consultation, and treatment of all women with actual or suspected major complications of pregnancy should be considered particularly in the presence of increased blood pressure, persistent albuminuria, in a clean catch specimen, or both, since the prevention of pre-eclampsia is one of the chief goals of prenatal care.

Derived in part from Manual of Standards in Obstetric-Gynecologic Practice — The American College of Obstetricians and Gynecologists.

MATERNAL HEALTH DESK REFERENCE CARD NO. 5

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Immediate Post Partum Hemorrhage

There are very few more sudden, more abrupt, and more dangerous emergencies in all of medicine than an immediate post partum hemorrhage. The successful management of this catastrophe depends upon its anticipation, if possible, and upon prompt and almost automatic course of action when it occurs.

The three common causes are: uterine atony, retained placenta, or laceration of the birth canal.

PREVENTION There are certain conditions that are associated with an increased danger of post-partum hemorrhage.

1. Any condition that produces an over-distention of the uterus, such as multiple pregnancy, hydramnios, or an exceptionally large infant.
2. Any previous scarring of the uterus, such as a previous cesarean section, extensive myomectomy, or previous hysterotomy.
3. Inertia in the first stage of labor with poor uterine contractions.
4. Prolonged labor with maternal exhaustion.
5. Operative procedures, especially version and extraction.
6. Deep surgical anesthesia.
7. Any ante or intra partum bleeding, as from abruptio placenta, placenta previa, etc.

During their prenatal course, all patients should have their blood typed and an Rh factor determination performed. This information should be in the patient's chart on admission.

All birth rooms should be adequately equipped for prompt emergency care of the patient that is hemorrhaging. Adequate personnel should be available.

All patients admitted should have a hematocrit or hemoglobin determination.

Should any of the above predisposing conditions exist, certain preventative steps should be taken:

1. Blood should be made available.
2. When delivery becomes imminent, a 15 to 18 gauge needle or catheter should be placed in a vein, and kept open with 5 percent glucose and water. This latter precaution allows an oxytocic to be given intravenously after the birth of the infant or the placenta, it permits an infusion of an oxytocic in a dilution of 5 units in 500 cc glucose & water, it permits blood transfusion if this is necessary, and it permits withdrawal of blood for a clot observation test.

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DIAGNOSIS When a post-partum hemorrhage does occur, a definite and prompt routine of action is necessary.

1. The nursing attendant should as quickly as possible, give 5 units of oxytocic intravenously, as a single dose, draw blood sample for typing and cross-matching, start an infusion of 5 units of oxytocic in 500 cc of 5 percent glucose in water, and do a clot observation test when indicated. All this can be done with one needle insertion.
2. The physician should introduce one hand into the uterus, supporting that organ from the outside with the other hand. Any placental fragments should be searched for and removed. Systematic exploration for possible rupture follows, each lateral wall being palpated, next the fundus, then the anterior and posterior walls, with particular care in palpating the lower uterine segment. The cervix and vagina should be visualized. Adequate exposure is most important.
3. The attending physician should immediately request adequate help and consultation.

TREATMENT Uterine atony will usually respond to exploration and oxytocics (Pitocin, Syntocinon, & Ergot preparations), The infusion should be continued for several hours. An indwelling catheter is advisable to prevent overdistention of the bladder. Uterine packing or hysterectomy are seldom necessary.

Hemorrhage from retained placenta or fragments usually responds to the removal of the tissue.

Lacerations of the cervix and vagina should be detected and repaired promptly. Occasionally, a cervical laceration may be so extensive that hysterectomy is required. Rupture of the uterus demands exploration abdominally, and frequently hysterectomy. Rarely, the rupture can be repaired and the uterus spared.

Blood loss should be promptly replaced. When blood is not yet available, plasma expanders should be administered to maintain blood pressure.

Less frequent causes of immediate post-partum hemorrhage may be encountered. Hypofibrinoginemia (abruptio placenta, dead fetus syndrome, amniotic fluid embolus), other bleeding diatheses, and coagulation defects, placenta accreta, inversion of the uterus: all should be considered, and appropriate therapy instituted.

Prompt recognition, prompt management, and judicious blood replacement constitute the key to success in the management of immediate post-partum hemorrhage.

MATERNAL HEALTH DESK REFERENCE CARD NO. 6

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Premature Separation Of The Normally Implanted Placenta

This complication of pregnancy is an important contributor to maternal mortalities in the State of Michigan, but is even more of a contributor to peri-natal mortalities. In its severe form, still-birth often accompanies "Abruptio Placenta."

Abruptio Placenta must always be considered in the differential diagnosis of 3rd trimester bleeding, before or during labor. It is commonly associated with toxemia of pregnancy, pre-existing hypertension, with or without super-imposed toxemia, increasing maternal age, multiparity, uterine fibroids, renal disease, usually chronic glomerular nephritis, and hydramnios with sudden decompensation from rupture of the membranes. It may also occur independent of these conditions.

PATHOLOGY

Maternal blood loss from the separated portion of the placenta, produces the clinical picture and possibly afibrinogenemia. The bleeding may be vaginal or hidden (often with more severe symptoms). As the separation increases, the uterus reacts with contractions which may range from productive, rhythmical contractions to board-like tetany. Pain, a prominent feature, is produced by stretching of the uterus by the retroplacental bleeding (concealed bleeding). Often the pain is localized by the patient to one area of the uterus.

CLINICAL PICTURE

The severity of symptoms and findings, vaginal or concealed, resulting pain, consistency and tenderness of the uterus, degree of maternal shock and condition of the infant, are determined by the degree of placental separation.

As the clinical picture worsens, the blood ceases to clot due to the reduction of circulating maternal fibrinogen. Fetal embarrassment, fetal jeopardy, and fetal death, occur in succession as the condition worsens.

MANAGEMENT

If the diagnosis is established or suspected, management should proceed as follows:

(1). Appraise the patient: a. as to the severity of the disease, b. and the state of blood coagulability, c. estimate the probable length of labor, all things considered.

(2). Draw sufficient blood from the mother for typing and cross-matching, and for a clot observation test, as a simple method of determining blood coagulability. (5cc of blood in a clean tube should form a firm clot in 5-10 min.) A circulating fibrinogen level should be determined at this time, and followed at hourly intervals. (Normal — 150 mg% or more.)

(3). Start an infusion of 5 percent glucose in water, thru a large needle (No. 17 or 18).

(4). Call a consultant.

(5). Perform a vaginal examination with a double set-up:

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    a. To determine the degree of effacement and dilatation of the cervix.
    b. To rupture the membranes. This should always be done, once the diagnosis is established, no matter what type of delivery may follow.

(6). Give whole blood transfusions (fresh blood if available) as indicated by blood loss and degree of shock. Blood over 24 hours old is poor in fibrinogen. Blood loss is often under-estimated.

(7). Give human fibrinogen if hypofibrinogenemia exists, when there is failure to respond to fresh blood infusion.

(8). Delivery is the immediate goal for abruptio placenta and its complications, and should be effected by whatever route seems safest for mother and infant.
    a. VAGINALLY, if the cervix is "ripe," if the severity of abruption and hence the amount of shock and evident bleeding is not too severe, and if delivery can be expected in a very short time (consistent with maximum safety of mother and infant).
    b. BY CESAREAN SECTION, if the cervix is not "ripe," with expectation of a labor longer than 4-6 hours, if the hypofibrinogenemia is corrected or quickly correctable, in severe abruption, or if delay for vaginal delivery would jeopardize the life of mother and infant.

An excellent summary on Abruptio Placenta has been written by C. Paul Hodgkinson, MD, and John Neufeld, MD, appearing in Clinical Obstetrics & Gynecology, September, 1960, published by Paul B. Hoeber, Inc., Medical Division of Harper & Brothers.

"Because of the seriousness, as well as the risk of post-transfusion hepatitis, blood, plasma, or dried fibrinogen infusions should be rigorously restricted to those recipients with clear cut indications for its use" — communication from H. D. Anderson, Ph.D., Biological Products Section, Michigan Department of Health.

MATERNAL HEALTH DESK REFERENCE CARD NO. 7

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Toxemia Of Pregnancy-Pre-Eclampsia-Eclampsia

Toxemia of pregnancy is characterized by edema, hypertension, and proteinuria, first appearing during the second half of pregnancy, except with hydatidiform mole. It continues to be an important cause of maternal and infant mortality, but its progression can be prevented by early recognition and proper treatment.

ETIOLOGY

Not clearly established. Occurs more often in young primagravadas than in older multiparas. Mothers with diabetes, multiple pregnancy, hypertensive vascular disease, pyelonephritis, glomerulonephritis, and hydatidiform mole, are particularly susceptible.

PATHOPHYSIOLOGY

The toxemic process occurs in two phases (not clearly demarcated): sodium retention phase, and sodium retention plus vasoconstriction. Edema is based on sodium retention. The generalized vasoconstrictive phase causes hypertension, reduced renal blood flow, (decreased urinary output), and characteristic retinal changes (retinal sheen and decrease in caliber of retinal arteries). Cerebral ischemia is the cause of coma and convulsions.

DIFFERENTIAL DIAGNOSIS

Toxemia must be differentiated from hypertensive vascular disease, HVD plus toxemia, pyelonephritis, and glomerulonephritis. Retinal changes and complete urinalysis of a clean voided mid-stream specimen, aid in differentiating. Culture and colony count help to diagnose pyelonephritis. RBCs and casts in urine point toward glomerulonephritis. Toxemia produces albuminuria, but no WBCs or RBCs are found in urine, in early stages.

CLINICAL COURSE

First evidence of abnormality: weight gain exceeding one pound per week followed by edema, then proteinuria. Rise of 20-30 mm of Hg above base-line BP is suggestive. All signs are exaggerated as condition worsens.

CHARACTERISTIC SYMPTOMS

No symptoms of early pre-eclampsia, only physical findings of excessive weight-gain, edema, and blood pressure rise. Headache, blurred vision (edema of retina), scotomata, occur as late symptoms. Epigastric pain and vomiting indicate impending eclampsia.

PREVENTION

Best preventative is observation and early recognition, i.e., good prenatal care. Low sodium diet, restriction of activity (phenobarbital, ½ gr. qid, decrease in physical and emotional stress), careful, frequent observation, plus thiazide diuresis (if indicated) may prevent progression to generalized vasoconstriction and true toxemia.

TREATMENT

Principles

Recognize developing pre-eclampsia, apply available measures, and if no response, deliver.

Office Treatment

1. Restrict activity (as above under prevention).
2. With excessive weight-gain, prescribe thiazide diuretic (hydrochlorothiazide) 25-50 mg. daily; (chlorthalidone) 50 mgs daily to prevent progression.
3. Re-examine every 3-5 days.
4. If poor response, limit sodium intake to 2-4 Grams daily. With weight loss stable or dropping BP, and negative urine, re-examine every 3-5 days. Diuretic and anti-hypertensive effect of thiazides, may be potentiated by Acetazolamide, 250 mg. bid, every 3-5 days.
5. If patient fails to respond, with further weight gain, and has increasing edema and BP, proteinuria, or toxic symptoms, admit to hospital. DO NOT ATTEMPT IMMEDIATE DELIVERY. Stabilize the patient's condition before attempting delivery if this is possible.

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Hospital Treatment

1. Call consultant obstetrician.
2. Weigh patient daily and record.
3. Record intake and output.
4. Take and record BP at least four times daily.
5. Determine daily quantitative 24 hour albumin.
6. Check hematocrit and type and cross-match for available blood.
7. Check serum uric acid. (Thiazides may cause rise.)
8. Order low sodium diet (1.5 to 2.0 Grams).
9. Re-check hematocrit and uric acid every 3 days.
10. Continue diuretic therapy, if indicated. Successful therapy is suggested by: 1. weight loss, 2. stabilization or fall in BP, 3. reduced proteinuria, 4. stable hematocrit, 5. normal uric acid.

Patient should remain in hospital until cervix is ripe for induction, and should then be induced. Occasionally, if true recovery, may be sent home if under 32 weeks gestation. Persistent albuminuria is indication for induction. If sent home, should be followed closely by obstetrician, and examined once or twice weekly.

Patients who have had eclampsia, must **NOT** be sent home until delivery is accomplished and adequate post-partum recovery is accomplished.

Failure of therapy is indicated by reversal of above findings (Paragraph 4 under office treatment), indicating progression to generalized vasoconstriction.

Treatment of Severe or Fulminating Toxemia

A variety of anti-hypertensive agents, alone or in combination, may be used, patient being monitored constantly.

Anti-hypertensive Agents

1. Reserpine, 2.5 mg. IM, every 12 hours, attempting to control vasoconstriction.
2. Hydralazine (Apresoline), 20-30 mg. IM or IV, slowly.
3. Veratum, 2.5 mg. IM, when diastolic pressure arises above 90 mm. Hg. as indicated.
4. Various combinations or other anti-hypertensives are available and useful. McCall's solution (Unitensen, 30 mg. and Apresoline, 20 mg. in 1000 cc of glucose in water) may be given as slow IV drip, provided physician personally remains at bedside during administration.

Other Measures

Many authorities advise administration of magnesium sulfate in eclampsia according to the following schedule.

a) 4 grams in 20% solution — IV — at the rate of one gram per minute, then 10 grams in 50% solution IM (3″ needle No. 20).
b) If convulsions continue repeat 4 grams in 20% solution IV.
c) 5 grams in 50% solution IM q 4 hours until delivery and for 24 hours after.

CAUTION: a) Patellar reflex must be present
b) Urinary output greater than 100 cc every 4 hours.
c) Normal respiration must be present.

If convulsions occur, pentobarbital sodium, slowly IV, will usually control them.

When severe pre-eclampsia or eclampsia is stabilized, usually accomplished in 12-48 hours, DELIVER THE PATIENT. Medical induction with oxytocic drip often succeeds even with unfavorable cervix. If not in active labor in 8-12 hours, deliver by Cesarean Section.

Abruptio Placenta may accompany toxemia (See Desk Reference Card No. 6).

POST-DELIVERY CARE

Continue pre-delivery care until:

1. BP is stabilized, 2. Urinary output is adequate, 3. Symptoms are relieved.

Essential Hypertension

Women with essential hypertension are prone to develop acute toxemia with similar signs, but more fulminating course. Treatment is similar to Pre-eclampsia.

Abruptio Placenta can usually be prevented by early delivery if acute toxemia develops.

MATERNAL HEALTH DESK REFERENCE CARD NO. 8

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)
(The material below is derived from Technical Bulletin No. 5, March, 1965, edited by the American College of Obstetricians and Gynecologists)

Infant Resuscitation

All obstetricians, anesthetists, house officers, and nurses assigned to the delivery room should receive detailed instructions and supervised training in the resuscitation of newborn infants.

Responsibility for the organization, implementation, and supervision of such training should be clearly established in all hospitals caring for maternity patients. Often this is shared by the Chief of Obstetrics and Gynecology with the Chief of Anesthesiology. Resuscitation of the newborn in the delivery room is the responsibility of the attending obstetrician. Situations in which resuscitation is required often occur unheralded. The most experienced person present in the delivery room should be delegated by the obstetrician to assist in the establishment of respirations. He should not delay calling those skilled and experienced in administering positive pressure oxygen and in intubating the larynx to assist him or to assume the responsibility for resuscitation when these methods might appear needed.

The fundamentals of establishing respirations and of active resuscitation of depressed infants are outlined in this section.

Fundamental Principles

1. The normal newborn baby usually breathes within a few seconds after delivery. Most will establish respiration within one minute and need little or no assistance. Some, however, may require active resuscitation.
2. Amniotic fluid will flow from the mouth and nose by gravity. Thick fluid or mucous requires direct pharyngeal aspiration.
3. Prolonged pharyngeal stimulation (as with a catheter) may inhibit respiratory efforts and decrease the heart rate.
4. The basic principle in establishing respirations for the normal and for the sick infant is to provide an open air-passage as quickly and reliably as possible after birth.
5. The alert infant usually can open his own air-passage and keep it open. Depressed and comatose infants do not have the muscle tone and strength to open their air-passage against the force of gravity and surface tension. The simple maneuver of moving the tongue from the posterior pharyngeal wall either directly or by lifting the jaw forward will provide an open airway in most cases.
6. The physiological condition of the newborn infant should be assessed within one minute after birth. Several types of observation may help make this evaluation:
    a. General Condition. The newborn may be assessed as alert, depressed or comatose (the limp, "rag doll").
    b. Heart Rate. If the heart rate is below 100, hypoxia probably is present. The heart in the comatose infant cannot be heard at rates much below 40 per minute, but umbilical pulsation may be visible. The amplitude of umbilical pulsation often is a good indication of circulatory status in the newborn.
    c. Apgar Score. The newborn is rated 0, 1, or 2, in each of five categories: (1) heart rate, (2) rhythmic respirations, (3) muscle tone, (4) reflex irritability, and (5) color. A score may range from 0 to 10; a baby with a score of 10 is a near-perfect baby, physiologically. (Apgar ratings should be determined at one and five minutes.)

Management of the Newborn

1. GENERAL
    a. KEEP THE HEAD AND FACE OF THE INFANT DOWN AND THE MOUTH OPEN AT ALL TIMES DURING AND IMMEDIATELY AFTER DELIVERY.
    b. During or immediately after birth gently aspirate the nasopharynx or oropharynx once or twice with a soft rubber bulb syringe or a suction catheter.
    c. After the cord is clamped, the infant should be placed on the receiving table where further care may be given. The infant should be evaluated at this time and the decision made as to necessary resuscitative steps. If possible, this should be done within one minute of birth.
    d. Procedures such as care of the eyes, complete physical examination, et cetera, should not be done until spontaneous respirations are well established.
    e. It is important that the infant be observed carefully during the first ten minutes of life to insure that adequate respiration continues.
    f. The infant should be wrapped to maintain normal body temperature.
2. THE ALERT INFANT, APGAR SCORE 8-10, HEART RATE OVER 100.
    No additional treatment other than continued observation is necessary.

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3. THE DEPRESSED INFANT, APGAR SCORE 5-7, HEART RATE BELOW 100.
   a. Place a two-inch thickness of rolled towel under the shoulders if the infant is in the supine position, or a one-inch thickness in the axilla if the semi-lateral position is chosen. Be certain that the head is hyperextended and that the tongue is pulled forward.
   b. Stimulate the baby by flicking and stinging the toes, feet, or buttocks, and by blowing cold oxygen over the face. Too vigorous and too painful stimuli may, however, add to the depression.
   c. Occasionally additional pharyngeal fluid may accumulate. This should be aspirated gently, but not continuously, until the infant shows active swallowing.

4. THE COMATOSE INFANT, APGAR SCORE 0-4, HEART RATE BELOW 100.
   a. The apneic or comatose baby needs prompt attention by trained personnel.
   b. This baby should be placed immediately on the receiving table, the head hyperextended, the airway cleared, and the pharynx carefully suctioned.
   c. Mild painful stimuli occasionally may serve to rouse the sleepy infant to respiratory effort.
   d. If apnea and depression persists for more than one minute, artificial ventilation should be instituted with mouth-to-mouth breathing, intermittent positive pressure oxygen with the bag and mask unit, or a positive pressure resuscitator. These should be accomplished by an operator familiar and skilled in the use of the apparatus and in maintaining a patent upper air-passage.
   e. Pressure between 15-20 cm. H_2O usually are safe for repeated inflations. Initial inflation, however, may require 25-35 cm. H_20, and, occasionally, 35-50 cm. H_2O. Several types of apparatus are available which deliver safe pressures, but at the present time no mechanical device for delivering oxygen under pressure is sufficiently flexible to meet all situations. The use of alternating positive and negative pressures is of no proven value and may do harm.
   f. If the thorax does not expand with intermittent positive pressure oxygen, laryngospasm and/or obstruction from the tongue may be present. Correct the latter with pressure at the angles of the mandible or with proper placement of an oropharyngeal airway. Laryngospasm can be treated by forceful prognathous and positive pressure oxygen or tracheal intubation.
   g. Intubation of the larynx should be done by those skilled in this technique. It is indicated in the following conditions:
      (1) If the improvement in the normal depressed infant has not been obtained after pharyngeal and laryngeal toilet and intermittent positive pressure oxygen.
      (2) For the obviously limp, "rag doll" baby regardless of heart rate and despite occasional gasps.
      (3) For any episode of cardiac arrest in the infant, including stillborn infants delivered for fetal distress.
      (4) For tracheal aspiration of infants born in thick meconium or infected amniotic fluid.
   h. Intubation of the larynx should be done under direct vision using a proper infant laryngoscope.
      (1) After inserting a snug-fitting endotracheal tube, foreign particulate matter (vernix, blood) should be aspirated once through the tube before blowing gas into the lungs.
      (2) Intermittent positive pressure oxygen should be given by mouth-to-tube, bag and mask, or mechanical resuscitator. High pressure may be necessary initially to inflate the non-aerated lung. Subsequent inflations are administered at lower pressures.
      (3) The pharynx should be cleaned of fluid before removing the endotracheal tube because gastric content may accumulate in the pharynx subsequent to ventilation of the lungs.
   i. External cardiac massage is indicated if 30 seconds of lung ventilation do not produce signs of improving circulation. This is done by compressing the heart between the sternum and the vertebral column.
   j. Intracardiac adrenalin is indicated at one minute if ventilation of the lung and external cardiac massage do not show signs of improving circulation. 2.0 cc. of a 1:10,000 solution of adrenalin in saline are introduced through a 1½" needle 2 cm. from the midline in the fourth intercostal space.
   k. Respiratory stimulants are of no value (Metrazol, Alpha-lobeline, Coramine, et cetera). (Nalline hydrochloride may be of value in the prevention of narcotic apnea in over-dosage of the mother).

5. ADDITIONAL MEASURES.
   a. Record the infant's condition at birth and the Apgar Score at one minute. Also record the time of sustained respirations. In addition, record all resuscitative efforts on the Newborn Physical Examination sheet.
   b. Every infant should receive a careful physical examination in the delivery room to discover congenital malformations. If dyspnea, cyanosis, stertor, or excess pharyngeal secretions persist, diagnostic studies to rule out pneumothorax, tracheo-esophageal fistula, diaphragmatic hernia, and hypoplasia of the lung should be made before transfer to the observation nursery. A 10 Fr. suction catheter should be passed into the pharynx to rule out choanal atresia. Passage of a catheter into the stomach will help diagnose a tracheo-esophageal anomaly.
   c. Antibiotic administration should be carefully considered after extensive resuscitative measures.
   d. Transfusion is indicated when the baby shows extreme pallor and shock secondary to fetal blood loss. It should be seriously considered if one infant of a multiple pregnancy is alert and the other shows depression and pallor.
   e. CO_2 levels should be determined as quickly as possible.

6. INDICATIONS FOR EXTENDED SPECIAL ATTENTION.
   a. Resuscitated infant — initial Apgar Score of 4 or less, comatose at birth.
   b. Premature infants.
   c. Infants delivered by cesarean section.
   d. Infants with congenital malformations.
   e. Infants of diabetic mothers.
   f. Respiratory distress syndrome.
   g. Iso-immunization.
   h. Maternal drug addiction.

MATERNAL HEALTH DESK REFERENCE CARD NO. 9

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

The Management of the RH- Sensitized Patient

1. An Rh determination and an antibody screen for atypical antibodies should be done on all maternity patients at the time of the initial visit to the physician or clinic. If the antibody screen is positive, the antibody should be identified and titered. If the screen test is negative, the screen test should be repeated at 26-28 weeks.

2. If the patient has antibodies in the Rh system, amniocentesis should be performed at 28-29 weeks and repeated at intervals, according to the results. If there is a history of previous still-births or fetal hydrops, it should be done earlier (24 weeks).

TECHNIQUE OF AMNIOCENTESIS

1. The amniocentesis should be performed one inch below and one inch lateral to the umbilicus, on the side of the fetal small parts, or in any area where fetal small parts are palpable. (It may be necessary to obtain a single anterior-posterior film of the abdomen to be sure.) Be sure the patient's bladder is empty.

2. The abdomen should be prepared with the same careful technique used for abdominal surgery.

3. The site chosen and the underlying tissues should be anesthetized with a local anesthetic agent such as 1 percent Xylocaine.

4. While holding the fetal head with one hand, a 5 inch, 18 gauge spinal needle with stylet should be introduced into the amniotic cavity. Release the needle so that if it contacts the fetus the point will move freely.

5. Remove the stylet and withdraw 10 cc. of amniotic fluid into a sterile syringe. Replace the stylet and withdraw the needle.

6. It is important to put the fluid immediately into a sterile opaque container to *prevent exposure to light.*

7. As soon as possible after the amniocentesis, centrifuge the fluid for 15 minutes (a standard centrifuge is satisfactory) and remove and save the supernatant. This will remove any blood or vernix which might interfere with the examination.

8. The fluid may be preserved for several weeks, refrigerated in a sterile container, without loss of critical absorption peaks if it is not exposed to light.

9. If fluid is not obtained on the first attempt, choose another area and repeat the procedure. If blood is obtained, a sample should be sent for blood type and Rh determination, and a second tap should be attempted. Blood obtained will usually be maternal blood. If it should be fetal, Coombs and hemoglobin determinations will give much information about the condition of the infant.

POSSIBLE DANGERS

1. Increased sensitization of the mother. This is theoretically possible but seems to be a very infrequent incident.

2. Injury to the placenta. This too has been reported but infrequently.

3. Injury to the baby. Because of this possibility, it has been suggested that the fetal position be determined accurately and the needle be pointed away from the fetal head.

4. Amnionitis. Sterile technique is most essential.

EXAMINATION OF THE FLUID

The fluid is examined in a spectrophotometer. The absorption curve consists of the optical density plotted against the wave length of the light passing through the fluid at various wave lengths between 350 and 650 millimicrons. This is plotted on a logarithmic scale. The difference of the optical density at 450 mu between the speci-

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men and the normal is determined. This difference is the figure reported by the laboratory. It is then plotted on the accompanying chart.

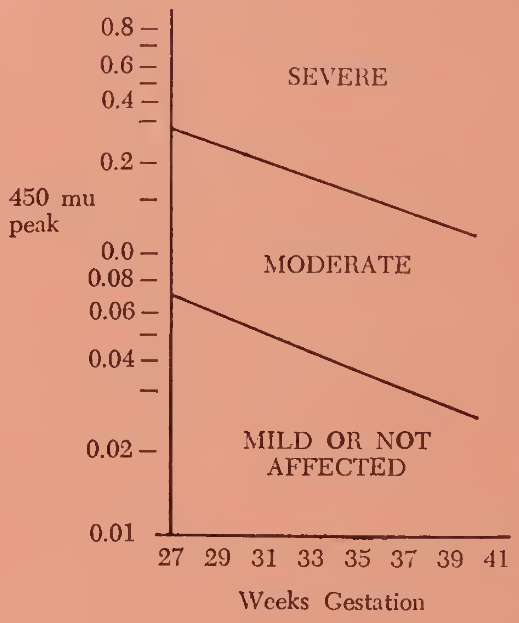
The attending obstetrician who is not well versed in these procedures should seek consultation at an early stage of pregnancy.

INTERPRETATION OF THE RESULTS

1. If the figure reported is low and remains low at the time of the second amniocentesis, the infant will be Rh negative, or Rh positive but mildly affected by the disease. Spontaneous labor may be allowed to ensue. This does not mean that the infant may not require exchange transfusion. It does mean that the baby will be born with an adequate hemoglobin and in good condition for the exchange transfusion.

2. If the figure reported is in the mid range, the infant will probably require exchange transfusion and should be delivered prior to term. The higher a reading in the middle zone, the more urgent is the indication for early delivery. Babies with repeated upper zone readings should be delivered as soon as they are mature (usually 36 weeks).

3. If the figure reported is high (in the severe range), there is no question that the infant is severely affected by the disease. An intra-uterine transfusion should be considered unless the infant is mature enough to be delivered. This is especially important if this mother has lost previous infants from erythroblastosis.



TIMING OF AMNIOCENTESIS

1. Initial fluid taken at 28 weeks.

2. Low and low middle zone reading: Repeat in two weeks.

3. High zone readings: Repeat in one week. If less than 36 weeks, transfuse. If 36 plus weeks, deliver. At 26-28 weeks, repeat tap weekly.

4. Middle zone readings: Repeat taps at 10 day intervals.

PROGNOSTICATING FROM SERIAL READINGS

1. Falling values indicate less severe disease, eg 1. upper middle zone, 2. lower middle zone – the infant may be only moderately affected – some have even been Rh negative.

2. Rising readings indicate a worsening condition. A rise into the high zone is very serious. Intra-uterine transfusion or immediate delivery are usually indicated, depending on fetal maturity.

In communities where laboratory facilities are inadequate for testing the supernatant amniotic fluid, specimens may be mailed to either of the addresses listed below:

1. c/o J. Robert Willson, M.D.
Professor & Chairman, Dept. of Obs & Gyn, Women's Hosp.,
U. of Mich. Medical Center
Ann Arbor, Mich. 48104

2. T. N. Evans, M.D.
Professor & Chairman, Dept. of Obs & Gyn, Wayne State University of Medicine
1400 Chrysler Expressway, Detroit, Mich. 48207

Complete identification of the specimen and a short history would be of value, and either of the above will offer consultation in management.

MATERNAL HEALTH DESK REFERENCE CARD NO. 10

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Ectopic Pregnancy

Since the great majority of pregnancies occurring outside the uterine cavity will be found in the tube, this discussion will be focused upon the diagnosis and treatment of tubal pregnancy. Being constantly alert to the possibility of a tubal pregnancy in any woman in the reproductive age is imperative if it is to be diagnosed and treated before serious complications develop.

SYMPTOMS AND DIAGNOSIS

Postponed, protracted, or any abnormality of menstruation would be suggestive of extra-uterine pregnancy. When accompanied by pain, often vaginal bleeding, low-grade fever, leukocytosis, and/or a mass to one side of the uterus, ectopic pregnancy must be the major working diagnosis until proper evidence can exclude it.

Symptoms vary with the stage of the disease when the patient is seen — before, during or after rupture.

Before rupture the pain is vague. Perhaps it may be felt as discomfort, indefinite distress, soreness, or very mild cramps. There is no fever or leukocytosis because there is little peritoneal irritation from blood in the abdomen. Often the mass is too small to be palpated on bimanual examination.

During rupture a positive diagnosis is more easily made. The pain is more severe, located on one side of the lower abdomen, with frequent referred shoulder pain. Exacerbation of pain followed by complete relief is particularly significant. The cervix is exceedingly sensitive to movement. Vaginal bleeding may be intermittent or constant, but seldom is it profuse. Fever and leukocytosis may be present because there is bleeding into the peritoneal cavity. A tense, pulsating, exquisitely tender mass now is usually felt with ease.

After rupture, the diagnosis is usually easy because of the history of agonizing, one-sided pain, signs of massive internal hemorrhage, followed by nausea, vomiting, fainting, shock and collapse. The pulse is rapid and feeble, and the skin is cold and pallid. In addition there is shallow breathing, air hunger, restlessness, and extreme anxiety.

On the affected side, the abdominal wall is tender and rigid, and a soft doughy mass may be present. At times it may extend over the entire abdomen.

In addition to the above symptoms and findings, there often is a significant past history of infertility, "one child sterility," or a previous ectopic pregnancy.

PROCEDURES USED IN ESTABLISHING A DIAGNOSIS

1) Pregnancy tests, if positive, will demonstrate the presence of living chorionic tissue. If negative, the test is valueless.

2) Pelvic examination, usually without anesthesia, is essential.

3) Culdocentesis can be an important aid, and is indicated in any suspected case. With the patient in the lithotomy position, the posterior lip of the cervix is pulled an-

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teriorly with a tenaculum and the vaginal wall is punctured approximately ¾" posterior to the cervix, using a long No. 16 or 17 needle, which has been slightly blunted, and a 10 c.c. Luer-lok syringe. If free, blood-stained watery fluid is obtained, the diagnosis of intra-abdominal bleeding is indicated, and if the fluid removed does not clot, it is established.

4) Dilatation and Curettage may be helpful when reports can be obtained promptly. The presence of chorionic villi is proof of intra-uterine pregnancy, but the finding of decidua without villi is suggestive of tubal pregnancy. (Decidua may be found post-abortion.)

5) Posterior colpotomy and culdoscopy may be helpful for those trained in these techniques, but it is recommended that proper exploration of the pelvis and salpingectomy is always accomplished more definitively and safely through a lower abdominal incision.

DIFFERENTIAL DIAGNOSIS

This is concerned chiefly with the differentiation from abortion, salpingitis, appendicitis, and pelvic tumor.

In abortion the bleeding is usually more profuse, the pain intermittent as uterine cramps. Villi and fetal parts may be seen in the expelled material.

In salpingitis there may be known gonorrhea, positive smears, purulent discharge, gradual onset, no enlargement or softening of the uterus, and a less circumscribed (usually bilateral) mass.

In appendicitis there are no menstrual abnormalities, no evidence of pregnancy, and usually no mass.

Ovarian cysts are usually much larger than a pregnant tube, pain is uncommon, menses have usually been normal, and the uterus feels non-pregnant.

Mittelschmerz occurs at mid-cycle.

MANAGEMENT

It is best to remove the offending ectopic gestation as soon as possible after the diagnosis has been established. Prompt operation before or during rupture will avoid the frank bursting of the tube with its tragic consequences.

In acute tubal rupture, blood should be drawn for CBC, Rh testing, typing and cross-matching, and IV fluids started with a large gauge needle or catheter. A second intravenous route should be established. An operating room should be ready and operation begun at once. Blood should be transfused as soon as available. Those who await recovery from shock lose precious time and more precious blood.

Rapid entry into the peritoneal cavity is essential. Palpation should promptly reveal the side involved, and clamping and ligation will control bleeding, often with dramatic improvement in blood pressure and general condition of the patient. Peritonealization should be attempted, if feasible. In massive hemoperitoneum, sacrifice of the ovary may be unavoidable. In cases diagnosed before rupture, preservation of the tube may be possible.

The operation should be quickly done and no other elective operation should be considered. When the bleeding is stopped, do no more — "get in and get out."

Removal of clotted and unclotted blood found in the peritoneal cavity may be helpful in prevention of peritoneal irritation, infection, and formation of adhesions, with subsequent damage to the remaining tube.

MATERNAL HEALTH DESK REFERENCE CARD NO. 11

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Diabetes and Pregnancy

1. Pregnancy is accompanied by diabetes in 2 per cent of cases. Pregnancy aggravates the diabetic state and diabetes in turn seriously affects the outcome of pregnancy. Maternal mortality is not increased despite the fact of increased maternal morbidity. There is a considerable perinatal mortality – the classic accident being fetal death in utero.
2. **DETECTION:** is most important. A urine analysis should be performed at each prenatal visit. Glycosuria must always be investigated. Attention is directed in addition to those women who have any of the following: a family history of diabetes, history of a birth of an infant weighing 9 lbs. or more, unexplained stillbirth, anomalies, unexplained by diagnosis, obesity or suggestive vascular lesions. Minimal investigation would involve securing a fasting and 2-hour postprandial blood sugar level. Levels above 110 and 130 (true glucose) suggest diabetes, and above 130 and 150 are diagnostic of overt diabetes.

   In the absence of frank diabetes a 3-hour glucose tolerance test should be done after the administration of 100 grams of glucose orally. Normal result – fasting 90, 1 hour 165, 2 hours 145, 3 hours 125 (mgm% true glucose). If two or more of these levels are exceeded but the fasting level remains less than 110 mgm%, the patient must be regarded as having chemical diabetes.

   For a valid result the patient must have had normal dietary intake for 3 days prior to the test and must have retained the glucose load.

   It may be necessary to recheck a questionable result in the succeeding trimester. After delivery gestational diabetes clears very rapidly so that a positive glucose tolerance test may not be obtained in the puerperium.

   Renal glycosuria occurs frequently during pregnancy, presumably due to a marked increase in the volume of glomerular filtrate.
3. **CLASSIFICATION:** (Priscilla White)
   - A. Chemical diabetes (abnormal response to glucose tolerance test).
   - B. Diabetes with onset after the age of 20 years and less than 10 years in duration.
   - C. Diabetes with onset between the ages of 10 and 19 years or of from 10-20 years duration.
   - D. Diabetes with onset prior to 10 years of age or of more than 20 years duration or having demonstrable retinal or leg vessel changes.
   - E. Diabetes with roentgen signs of pelvic vascular disease.
   - F. Diabetes with nephropathy.
   - G. Diabetes with multiple obstetric failures.
4. **EFFECT OF PREGNANCY ON DIABETES:**

   Pregnancy makes increasing demands on maternal insulin reserve and is thus diabetogenic. Subclinical diabetes is unmasked and overt diabetes worsened. The degeneration of carbohydrate tolerance is most marked during the second and third trimesters. The risk of ketosis and acidosis is increased. There is an increased incidence of toxemia related to preexisting vascular disease. There will be a progression of complications such as nephropathy.
5. **EFFECT OF DIABETES ON PREGNANCY:**

   There is no impairment of fertility or increase in abortion rate in the adequately treated diabetic. The principal effects are upon the fetus which is liable to unexpected intrauterine death in the last weeks of pregnancy. At birth the infants are large, edematous and suffer from inadequate pulmonary ventilation. The infant must often be delivered prematurely. 2-3% of the infants have serious anomalies in the cardiovsacular or gastrointestinal tracts.

   The perinatal mortality is 10-15% in good clinics ranging from 5% in Class A to about 50% in Class D. The appearance of toxemia or diabetic acidosis markedly increases perinatal mortality.
6. **TREATMENT OF THE PREGNANT DIABETIC:**

   Care should be given concurrently by the obstetrician and internist. Class A: Diet, close supervision and delivery at or near term. A small daily dose of NPH insulin sufficient to maintain the postprandial blood sugar within normal limits (130 mgm % or less), will minimize the characteristic fetal changes in these patients.

   Class B, C, D, & E: All require insulin (oral hypoglycemic agents have not been accepted for use in pregnancy). The maternal insulin requirement increases and as a result more than one daily dose of insulin may be required.

   Diet must be constructed to permit a normal weight gain with reference to the patient's ideal weight (30 calories per kgm of ideal weight) and should contain a minimum of 1.5 gms/kilo of protein, 40% of the total carbohydrate and the remainder fat.

   Control should be such as to maintain fasting and 4:00 P.M. blood sugar below 130 mgm %.

   Hospitalization should be resorted to freely for the control of the diabetic state and any medical or obstetric complications.

7. TIMING OF DELIVERY:
   The patient with Class A diabetes may be delivered at or near term in the absence of complications or an over large infant but should not be allowed to go beyond term.
   The patient with insulin dependent diabetes Class B, C, D, etc., should be delivered between the 36th and 38th weeks, either vaginally after induction of labor or by cesarean section. Prolonged induction should be avoided.
   Serial total urinary estriol output is one index of the integrity of the fetoplacental complex. Beyond 35 weeks, levels below 12 mgm. are unsatisfactory, and levels below 5 mgm., if confirmed, are considered critical.
   Nephropathy is an indication for therapeutic termination of pregnancy.
8. THE INFANT OF THE DIABETIC MOTHER: often delivered prematurely should be observed for the following:
   1. Respiratory Distress.
   2. Hypoglycemia (beginning about 2 hours after birth, commonly transient blood sugar level should be checked on cord blood and at 3 and 7 hours and calories given early by the oral or intravenous route).
   3. Hyperbilirubinemia.
   4. Hypocalcemia (stridor, tetany).
   5. Increased hematocrit with possible venous thrombosis.
   6. Increased incidence of major anomalies.

   Qualified pediatric supervision is a prerequisite to the care of the newborn of the diabetic mother.

ESTRIOL EXCRETION IN PREGNANCY

RATIONALE: Estriol excreted in the urine of pregnant women serves as a valuable indicator of fetal well-being. Estriol excretion reflects fetal status for two reasons: a) the bulk of maternal urinary estriol is produced by fetus and placenta, and the fetus is mandatory in estriol biosynthesis. b) Estriol transfer to the mother is rapid and virtually complete. The mother excretes estriol without major delay or further metabolism into the urine. Thus maternal urinary estriol excretion reflects truly and promptly its feto-placental production. Fetal distress and/or placental insufficiency cause a rapid decrease in estriol production, and estriol excretion drops without delay.

WHEN ARE ESTRIOL DETERMINATIONS HELPFUL?

Estriol determinations are helpful in any situation where fetal distress is suspected and termination of pregnancy might reduce the risk of intrauterine or neonatal fetal death. Normal estriol excretion indicates fetal well-being and allows the continuation of pregnancy, thus preventing unnecessary prematurity and reducing the risk of perinatal mortality.

Estriol excretion is routinely measured during the last 10 weeks of pregnancies complicated by DIABETES, HYPERTENSION, TOXEMIA and POSTMATURITY.

Serial estriol determinations are preferred since there are daily individual variations, largely due to fetal size. The larger the fetus, the more estriol is produced and excreted. Constant or increasing estriol excretion, checked twice weekly (or more frequently in certain cases) during late pregnancy when termination of gestation would be feasible, indicates good fetal development.

Extremely low estriol values indicate FETAL DEATH.

WHEN MIGHT ESTRIOL DETERMINATIONS BE MISLEADING?

1. In cases of RH-ISOIMMUNIZATION, urinary estriol determinations do not indicate hazards to the fetus.
2. Low estriol excretion might be found in cases of MATERNAL ADRENAL INSUFFICIENCY and ANENCEPHALIC BABIES, while the fetus does perfectly well.
3. MATERNAL KIDNEY FAILURE causes low estriol excretion despite normal estriol production by a well-functioning feto-placental unit. Plasma estriol determination may help in these cases.

METHODOLOGY

Urinary estriol is measured in the Gynecologic Endocrine Laboratory, Women's Hospital, University of Michigan Medical Center on 1% or 0.5% aliquots of a 24-hour urine collection. Radioactive estriol glucosiduronate is added before analysis to the urine. This is the form in which more than 90% of the estriol is excreted during late pregnancy. This addition of radioactive material permits correction for procedural losses. Our method eliminates any technical error and provides accurate, precise and specific results.

ACCURACY:	100.5% ± 2.2% recovery of estriol glucosiduronate added to 10 ml urine of a normal male subject.
PRECISION:	± 4.3% (Standard deviation).
SPECIFICITY:	The material measured is chromatographically pure.
TIME FOR ASSAY:	One working day = 8 hours.

NORMAL VALUES

The following table indicates normal values of estriol excretion during the 2nd half of gestation.

Weeks of Gestation	Estriol mg/24 hrs.	Weeks of Gestation	Estriol mg/24 hrs.
20	7	32	22
22	9.3	34	26
24	11.1	36	31
26	13.5	38	36
28	16	40	45
30	19		

HOW TO SEND SPECIMENS

Approximately 40 ml of a well-mixed total 24-hour urine collection are required. The result cannot be more accurate than the urine collection and the measurement of its volume ("total volume"). The Gynecologic Endocrine Laboratory supplies plastic containers and mailers upon request. The containers include a preservative. Mailing by "Special Delivery" is strongly recommended. When sent by special delivery, the specimens are usually received on the morning following the day they have been mailed. The results are given by telephone. Completion of the short questionnaire included in the mailers furnishes all information which is necessary for a useful interpretation of the results.

The Gynecologic Endocrine Laboratory
Uwe T. Goebelsmann, M.D.

MSMS, AMA Recommendations Offered Re Medical Society Acceptance of Federal Funds

Guidelines have been developed and approved by The MSMS Council for acceptance of federal funds by a medical society. The formal action by The Council is reported in the official minutes of The Council, outlining the following recommendations:

MSMS RECOMMENDATIONS

"One — That the Recommendations of the AMA Council on Medical Service as approved by the AMA House of Delegates be accepted as guidelines for MSMS policy. (The AMA guidelines follow)

"Two — That all programs involving direct use of government funds by component societies be presented to The Council, MSMS, for evaluation.

"Three — That information be obtained from other state or county medical societies who have established mechanisms such as a foundation, nonprofit corporation, or other entity, separate from the society itself and served by independent administrative staff providing direct operational administration of government funds, without involvement of the medical society as a body, and that this information and the above guidelines be disseminated to component societies, and be a part of some early conferences of the MSMS."

These three recommendations now are part of MSMS policy.

AMA RECOMMENDATIONS

A Council on Medical Service report regarding medical society participation in government medical programs was adopted as amended by the House of Delegates. The Report set forth five recommendations providing guidelines to medical societies as follows:

"1. That this Association reaffirm past recommendations that state and local medical societies assume active responsible leadership in reviewing and setting standards for existing health services in their communities and in the evaluation, planning, developing, improvement, and augmentation of appropriate existing and new services.

"2. That this Association affirm the principle that state and local medical societies including federal funds, in conformity with recommendation #3 below, but only when such funds are essential for the society to maintain its proper role in the development of community health services and when formal agreements permit the society authority over the provision of medical care in accordance with the Principles of Medical Ethics.

"3. That this Association affirm that, in the continuance of its role of responsible leadership, a state or local medical society may enter into agreements with government agencies to administer health care programs and to have the administrative costs of such programs financed from governmental funds. The agreement must provide that such administration does not contravene the ethical precepts of the profession or interfere with the individual physician's freedom to exercise his professional judgment to protect the best interest of the patient. The society should use some mechanism such as a non-profit corporation or other entity, separate from the society itself, and serviced by an independent administrative staff, where possible, to avoid direct operational involvement of the medical society as a body.

"4. That this Association reaffirm its long-established policy that personal care is primarily an individual responsibility and that federal aid in financing care for those unable to pay should be provided only in conjunction with other levels of government — community, county and state. In individual situations, federal grants for research, demonstration, or pilot projects in methods of providing and financing health services may be permissible, but only under the condition that such new mechanisms, if found useful, be incorporated into the ongoing federal state-local programs for those in need, and, for those not in need, the usual private medical care financing methods were appropriate.

"5. That this Association point out that there are hazards to the medical society in involvement in government programs, whether at the developmental or the operational level, and that such involvement should be undertaken only after detailed study and review by the members of its potential impact. Any operational role undertaken by the society in such a program should be conditioned on the society's also having a voice in the planning, and any change in the society's role should be conditioned on prior review and consent by the society. Any contractual agreements entered into by the society, in regard to such programs should be for specific, limited periods of time, preferably not more than one year, and should be renewable only on agreement by the society."

ACTIVITIES, PROJECTS

Laboratory Facilities Council to Implement New Licensing Law

The Laboratory Facilities Council, a new advisory group to the State Department of Public Health, has been named in implementing a state law effective January, 1969 requiring the licensing of clinical laboratories.

The Council members are: Leo Walker, MD, Lansing; Harold Bowman, MD, Grand Rapids; Norman W. Arends, DO, Flint; Edna Andrews, PhD, Detroit; Arthur Jordan, M.S., Detroit; Robert Foy, PhD, Lansing; and Eugene M. Britt, PhD, Ann Arbor. The Council held its first meeting October 30 to review proposed rules under Act 235, P.A. 1968.

The Council's principal responsibility will be establishing rules setting up standards for licensing laboratories in and out of hospitals with the usual procedures of holding public hearings and legal clearances by the State Attorney General before adoption.

Rawling Serves Again As Vietnam Volunteer

John C. Rawling, M.D., Flint, is in Vietnam serving the civilian population through the AMA Volunteer Physicians for Vietnam program.

The two-month stay is a return visit for Dr. Rawling who worked in Vietnamese hospitals and also on the SS Hope hospital ship at Saigon during 1961. In the intervening time he has lectured and helped to raise funds for the medical-assistance program. He also made another trip aboard the SS Hope, serving in Trujillo, Peru, in 1963.

HUME, POMEROY LEAD ORTHOPAEDIC SOCIETY

Leaders of the Michigan Orthopaedic Society are H. Ross Hume, M.D., Detroit, president; Richard W. Pomeroy, M.D., Lansing, president-elect, and George Stilwill, M.D., Lansing, secretary-treasurer.

The officers were elected at the annual fall meeting of the Society in Detroit.

MSU, STATE HOSPITAL BEGIN JOINT PROJECT

An affiliation with Pontiac State Hospital providing for instruction of resident physicians and Michigan State University medical students has been approved by the MSU Board of Trustees and the state hospital.

Planned programs include field trips and summer extern programs for MSU medical students, exchange of residents in psychiatry, and faculty appointments for qualified members of the Pontiac staff.

Academic appointments in the College of Human Medicine will be offered to the medical superintendent and other qualified physicians on the hospital staff.

Leach, McClendon Honored by NAACP

J. Leonidas Leach, M.D., Flint physician for 46 years, and James J. McClendon, M.D., a practicing physician in Detroit for almost 40 years, were recently honored by the Michigan State Conference of NAACP branches. Both men are members of the executive board of directors of the National Association for the Advancement of Colored People.

Doctor Leach was cited for "his pioneering efforts for freedom, equality and civil rights as an early president of the Flint chapter of the NAACP and former president of the Michigan State Conference." Doctor McClendon received a similar citation for his long leadership of the Detroit chapter. Doctor Leach was the first Negro president of the Michigan Academy of General Practice. Doctor McClendon has been active in many civic organizations including the Detroit Metropolitan Area Regional Planning Commission, the Baptist Church, YMCA, and Booker T. Washington Business Association.

MSU ADDS REHABILITATION SPECIALIST FROM OHIO

John F. Lane, M.D., of Cleveland, has been named medical director of the Rehabilitation Medical Center in Lansing and associate professor of medicine at Michigan State University. MSU reports that Doctor Lane will play "a major role in the development of a model community program for the rehabilitation of stroke patients."

Doctor Lane has been a physiatrist and neurophysiologist with the Department of Physical Medicine and Rehabilitation in Cleveland's Highland View Hospital, and also an assistant professor of medicine and an associate in the Department of Physiology at Case Western Reserve Hospital.

Mary Jordan, right, Eaton Rapids, president of the Michigan State Medical Assistants Association, acccepts the state's first-place publication award in the "states with membership over 200" category from Wilda Haines, Canton, Ohio, awards chairman, during the American Association of Medical Assistants convention in Columbus.

X-Rays Show Transplanted Teeth Successful at U-M

Clinical tests and X-rays were described by oral surgeons at the University of Michigan School of Dentistry last month which showed that teeth have been transplanted successfully between related patients.

In the operation performed in February 1968 under local anesthetic, two bicuspids were extracted from 16-year-old Margy Batten and transplanted into the upper jaw of her 13-year-old brother, Bill, both of Elkhart.

The girl's bicuspids were impacted — and her brother's had never developed, so the transplant was attempted. For six weeks the teeth were held in place with stabilizing wires, much like a regular brace.

Now, eight months later, X-rays show that a new layer of dentin is being formed inside the pulp canal; new sockets have developed in the jaw; and both teeth are viable. A conventional pulp test indicates that the nerve supply is migrating into the new teeth.

James R. Hayward, D.D.S., head of dental oral surgery at the University of Michigan Hospital, said, "Although heterogenous tooth transplants (between different individuals) have been attempted for centuries, this may be the first instance in which the teeth survived with a viable pulp."

Unlike the heart transplants, immunosuppressive drugs were not used in the tooth transplant.

MEDISCENE

Dec. 11 – Eighth Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit

Dec. 11-13 – 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing

Dec. 18 – The Council, MSMS Headquarters, East Lansing

Jan. 20-24 – Michigan Cancer Foundation and American College of Physicians, "The Internist and Total Cancer Care," McGregor Memorial Center, Wayne State University, Detroit

Jan. 29 – The Council, MSMS Headquarters, East Lansing

Jan. 30 – State Woman's Auxiliary to MSMS, Board of Directors, MSMS Headquarters, East Lansing

Feb. 3-10 – Childrens Dental Health Week

March 12 – The Council, MSMS Headquarters, East Lansing

March 20 – Second Annual Cancer Conference for Nurses, Michigan Division American Cancer Society, Rackham Building, University of Michigan

March 20-21 – AMA Conference on Rural Health, Philadelphia-Marriott Motor Hotel, Philadelphia

March 26-27 – Eighth Annual Michigan Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 30 – The Council, MSMS Headquarters, East Lansing

May 7-9 – Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 21 – Annual Muscle Symposium, Wayne County Medical Society Auditorium, Detroit

June 4 – The Council, MSMS Headquarters, East Lansing

July 13-17 – AMA Annual Meeting, New York City

July 31-Aug. 2 – MSMS Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls

Sept. 28 – The Council, Sheraton-Cadillac Hotel, Detroit

Sept. 28-Oct. 3 – Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit

SOCIO-ECON

Prizes Awarded in State Contest for Best Hospital Money-Saving Suggestions

Employees of 25 Michigan hospitals recently shared $5,000 in cash awards in the Tenth Annual Search for New Hospital Achievements, cosponsored by the Michigan Hospital Association and Michigan Blue Cross.

The presentations were made during the annual Mid-Year Meeting of the Michigan Hospital Association House of Delegates at Traverse City.

The judges were faculty members from Michigan State University's College of Business and Human Medicine.

Selected to receive the Grand Award in this year's contest was Mrs. Jean C. Woelfel, a registered nurse from Bon Secours Hospital in Grosse Pointe. Mrs. Woelfel's description of the hospital's disaster control drills utilizing "live" victims stressed the importance of staff preparedness and immediate action during disaster conditions.

Special Awards for "Achievement Directly Related to Patient Care" went to: C. M. Kopp, M.D., director of clinical laboratories for W. A. Foote Memorial Hospital in Jackson; and Ben Hashemi, chief pharmacist at Children's Hospital in Detroit.

Honorable mention winners include: Robert Cole, Michael Ward and William J. Weber, M.D., of Ingham Medical Hospital in Lansing.

24-44 Age Group In State to Grow Fastest, 1965-85

Michigan's projected population growth is changing in the size of the various age groupings, so reports the U.S. Department of Commerce, Bureau of the Census.

The accompanying chart depicts the changing age structure over the period from 1965 to 1985. It is estimated the population will increase 30%, with the 25-44 age category growing the fastest at 50%, while the 45-64 age bracket will remain relatively constant by increasing just 6%.

These changes will create additional demands on our economy to fulfill the varying needs of the people. Housing must grow to meet the specific requirements of retirees as well as family-formers; services, both personal and public, will have to match; recreational facilities should be developed and diversified in a way to satisfy both "grandma" and the "teenage swinger."

Employment availability needs to expand to accomodate the growing size of the 18-84 age group. Educational demands will vary during this period between K-8, high school, and college requirements; and, finally, our senior citizens will require additional medical care and increased social security benefits in line with the 41% growth of this group.

In a recent opinion survey of Illinois physicians, 81% of those polled favored government grants to newly graduated physicians who agree to practice a certain number of years in medically deficient areas.

EMPLOYMENT FORECAST FOR MEDICAL AND OTHER PROFESSIONAL SERVICES BY REGION — 1960 and 1980

Region	1960	1980	Change in Number	Change in Percent
Jackson Area	9,744	29,000	19,256	198
Benton Harbor - St. Joseph Area	8,168	24,000	15,832	194
Kalamazoo - Battle Creek Area	20,748	61,000	40,252	194
Lansing Area	20,031	58,000	37,969	190
Flint Area	17,527	50,000	32,473	185
Traverse Bay Area	6,457	18,085	11,628	180
Saginaw Bay Area	22,984	63,200	40,216	175
Grand Rapids - Muskegon Area	32,572	88,915	56,343	173
Alpena Area	2,646	7,200	1,554	172
Eastern U.P. Area	4,186	11,000	6,814	168
Western U.P. Area	7,625	20,000	12,375	162
Detroit 7 County Area	177,232	439,000	260,000	147

Source: 1960, *Growth Patterns in Employment by County*, U.S. Department of Commerce, Office of Business Economics.
1980 projection made by economics staff, State Resource Planning Division

The Role of the Non Physician In Utilization Review

BY GORDON TAAFFE
CARL JOSEPHSON
BOTH OF MICHIGAN BLUE SHIELD

A complete medical record is an accumulation of a variety of documents pertaining to the medical care a patient has received as a consequence of illness, injury, or the prevention of illness. For hospital patients, the documents are generated by diverse departments and people within the hospital. For example, patient identification data, complaint, present illness, past history, clinical laboratory reports, and X-ray reports are some of the kinds of information that find their way to the medical record, also known as the patient's case history or as charts.

Upon discharge from the hospital, the Medical Records' Librarian catalogues the various source documents in the case history in an orderly fashion and files the history for future reference. Future reference may be review of the case history by a group of physicians in order to evaluate the quality of medical care the patient received while he was hospitalized.

Typically, in utilization review of medical care, a group of physicians review the contents of a case history for evidence of quality of medical care contained in the history. There is a legal precedence for such a review for Medicare patients,[1] and there is also professional interest[2] in utilization review for all hospitalized patients. For example, the American Medical Association[3] approved a resolution with respect to the objectives of utilization review: the review committee should "evaluate the quality of medical care on the basis of documented evidence to support diagnosis, treatment, and justified utilization of hospital facilities." The review process, however, is subject to considerable variability.

IN THE FIRST PLACE, present methods of selection of cases for review do not insure that all cases which need to be reviewed will, in fact, be selected for the utilization review committee. Selection of cases for review is often relegated to the Medical Records' Librarian, for example, who may pick out well-kept case histories rather than representative cases of typical or unusual patterns of medical care. The review committee may select its own cases but, with a large number of cases of varying complexity, it is difficult to select objectively all of the case histories which need to be reviewed.

In addition, highly specialized care may require the evaluation of a specialist for adequate review and members of some of the highly technical specialties may not be on the review committee. Individual differences among physicians create considerable variability in the quality and quantity of reports entered in the medical record. In this respect, traditional hospital-based utilization review is subject to inter-hospital variation.

ALTHOUGH INDIVIDUAL case review of medical case histories by a group of physicians is basic to utilization review, the non medical professional has much to offer in creating uniformity and objectivity in the review process. The systems analyst, for example, could define precisely what information is needed in the case history that is both necessary and sufficient for an adequate review of that history. The operations researcher could determine parameters of medical care and objectively select case histories that depart significantly from the parameters.

Data accumulated by a prepaid group health insurance agency affords a broadly based utilization review system that would permit reviewing variability between hospitals and at the same time include home and office care with inpatient stay. A broadly based computer-assisted utilization review program would release the review physician from many time consuming administrative aspects of reviewing case histories and at the same time

> The reluctance of the physician to become involved in utilization review probably is due to a variety of reasons. Of these, the most important is his concern that it is another job that he doesn't have time to do. The purpose of this article (the fifth in a series on Utilization Review) is to show that the busy, dedicated physician doesn't have to do it alone; in many ways the non-medical professional can be helpful.
>
> —Louis F. Hayes, M.D.
> Vice President, Medical Affairs
> Michigan Blue Shield

give the opportunity for objectivity in selecting all cases which need review.

All cases needing review would be brought to the attention of the review physician through a computer-assisted review system based on parameters of medical care.

A DIVERSE GROUP of non medical professionals would be needed to implement the utilization review program outlined above. Data processing specialists, for example, would be key personnel to the system. Developing parameters of medical care based on length of stay, costs, and procedures for particular diagnoses and medical conditions is a highly technical problem. Statisticians and operations researchers would cooperate on this developmental aspect of the program. Computer identification of cases for review would be the first objective of this review program.

A by-product of the identification process would be a listing of selected cases with community standards for comparable cases. Secondly objectives would be a preliminary screening of selected cases prior to review. In this way, the review physician would not only have case histories whose records depart in some particular from standard medical practices, but he would also know what the standard is.

Although quality of care is evaluated against medical criteria, indexes of typical care are available to review physicians from a variety of non medical sources. Vital statistics, for example, provide much "base line" information about births and deaths in the general population as well as figures on the incidence and prevalence of diseases. The rapidly burgeoning field of medical economics is amassing data about the organization, administration, and delivery of medical services.

Medical economics is concerned with the costs of providing care and also with values received. Not only is medical care being evaluated in terms of surgery, laboratory services, drugs, length of hospital stay, and other strictly medical problems, but also health services are being considered with respect to cost-benefit analyses, patient satisfactions, type of practice, allocation and distribution of medical services in relation to demand for these services and many other aspects of the medical system. White[4] states "the term 'quality of medical care' has unfortunate pejorative connotations. It assumes, first, that there are objective methods for distinguishing 'good quality' from 'poor quality' care and, second, that there are a substantial number of physicians who much of their time do less than their best work." White suggests that the incidence of incompetence among physicians is low but that the circumstances under which a particular physician works can lead to inefficiency. Many standards and evaluative indexes of medical care can be derived from non medical disciplines. That is to say, those things contributing to the organizational efficiency of medical services and to the sociological and psychological evaluation of the end product of medical care can come in part from non medical personnel.

THE CONTRIBUTION OF THESE non medical personnel is distinct from the medical contribution but is relevant to the overall efficiency of the medical system. In summary, non medical personnel in utilization review can contribute to:

1. Uniformity and standardized medical records.

2. Development of computer-assisted techniques for identification of medical records in need of review.

3. Development of computer-assisted techniques for preliminary medical evaluation of patient care.

4. Assessment of community patterns of patient care.

5. Assessment of community attitudes and behavioral patterns toward medical problems.

6. Efficiency in the organization, administration, and delivery of medical care.

7. A broadly based utilization review system.

REFERENCES

1. Public Law 87-89, 89th Congress, H.R. 6675, July 30, 1965.
2. *Utilization Review: A Handbook for the Medical Staff.* American Medical Association, Chicago, 1965.
3. Op. cit., p. 9-11. "The Utilization Committee is a fact-finding, educational instrument of the medical staff . . . (that) devotes particular attention to . . . unnecessary admission, excessive length of in-patient stay, delay in use or over-use of X-ray, laboratory and other diagnostics and therapeutic services, and delay in referral."
4. White, Kerr, "Research in medical care and the health service system." *Medical Care,* Vol. 6, No. 2 (March-April 1968) pp. 95-100.

State Official Serves On HEW Grants Committee

Serving on the 18-member Grants Administration Advisory Committee of HEW is Paul H. Wileden, Director, Budget Division, Executive Office of the Governor, Bureau of the Budget of the State of Michigan.

The committee comprises eight members of the Department of Health, Education and Welfare and 10 public members who are involved in health, education and welfare programs in State Departments and State budget offices, public and private universities and hospitals, medical schools and private non-profit foundations.

LEGAL

LARYNGEAL NERVE DAMAGE IN THYROIDECTOMY

(Editor's Note: The following article is quoted from the AMA Citation newsletter of October 15, 1968, prepared by the AMA Law Department.)

A patient suing a physician for laryngeal nerve damage suffered in a thyroidectomy may rely on the physician's own testimony on the standard of care in order to establish a *prima facie* case of professional negligence against him. Setting aside a directed verdict for the physician, a Michigan appellate court remanded the case for a new trial on the issue of negligence in the performance of the operation. The court further held that there was no jury question as to the physician's alleged failure to obtain the patient's informed consent.

The patient had a normal woman's voice before the operation was performed in March, 1957. The physician noted during the operation that her laryngeal nerves were normal in appearance. After the operation, her voice was hoarse, rough, and harsh, and much different than it had been before the operation. The physician told her that the condition would clear up. However, the condition allegedly persisted until the time of the trial, nine years after the operation.

MEDICAL COLLEGE
GEO. CRENSHAW

"Let me know if this prescription works. I'm having the same trouble myself."

The patient consulted a second physician sometime after the operation. He diagnosed her condition as laryngeal nerve paralysis. That diagnosis was confirmed by physicians at two hospitals.

The physician testified that, although the laryngeal nerves are within the field of operation in a thyroidectomy, the nerves can and should be avoided. Since he had performed more than 100 thyroidectomies prior to the one involved here, he was qualified to testify as to the accepted standard of care in the community in the performance of a thyroidectomy, and the patient could rely on his testimony in attempting to establish a *prima facie* case.

Moreover, there was expert medical testimony tending to show a violation by the physician of his duty to avoid injuring the patient's laryngeal nerves, although such testimony was not as explicit as is desirable. While the patient's medical expert did not state that the patient's laryngeal nerve had been cut during the operation, he did state that there was an injury to the nerve that was attributable to the operation. In view of that evidence, a verdict should not have been directed for the physician.

There was, however, no jury question as to the physician's alleged failure to obtain the patient's informed consent to the operation. Whether a physician should, before operating, advise the patient of all possible results, so that he may intelligently give or withhold consent to the operation, depends on the accepted practices in the community. The patient testified that the physician did not explain anything about the thyroidectomy prior to its performance. However, there was nothing in the record to show that it was standard practice to discuss the possibility of laryngeal nerve injury. The physician testified that the patient was told what to expect by way of results. However, when, as here, the result is unexpected and caused by an allegedly negligent act, the lack of informed consent cannot be proximately related to the patient's injuries. — *McPhee v. Bay City Samaritan Hospital,* 159 N.W.2d 880 (Mich., March 29, 1968; rehearing denied, May 28, 1968)

from Vol. 18, No. 1

Physicians Can And Do Help Make State Laws

BY M. A. (MIKE) RILEY
MSMS LEGISLATIVE COUNSEL

On January 8th, 1969 the 75th Michigan State Legislature will swing into action in Lansing and, within a few weeks, organize itself and establish deadlines for the processing of approximately four thousand proposed bills during its two-year tenure.

It can reasonably be expected that well over 200 of these proposals to be made in 1969 and 1970 will suggest important new laws, or important amendments to existing laws, in the medical practice area. Perhaps an equal number of bills will relate in some way to the broader classification of "health care."

CLEARLY, THE MEDICAL profession has ample cause to take an active interest in the legislative process, since such a significant proportion of the matters considered by the State Legislature directly affect the practice of medicine and thus the quality and cost of care.

By the time of final adjournment of the Michigan Legislature in 1970 several scores of health law amendments or completely new laws will have been added to the statute books.

Every citizen of Michigan CAN have an impact on the decisions of the State Legislature, and this is particularly true in the case of doctors of medicine, because health legislation is nearly always technical in nature and those who must pass upon it genuinely require, and appreciate, the informed viewpoints of professionals.

Yet, no citizen, physician or non-physician, can have an impact upon the legislative process unless he avails himself of the means at his disposal to participate in that process. At times, of course, lawmakers will seek out public opinion (through polls, questionnaires, and the like) but far more frequently the bulk of opinion on a given proposal which is expressed to legislators comes to them through the initiative of the interested party.

WHEN A VITALLY important health law is under legislative consideration, therefore, which affects every citizen it should be expected that each lawmaker WILL hear from many people — people who take the time and trouble to write to him, wire him, telephone him, or actually visit with him either in his home area or in the State Capitol. Many people WILL avail themselves of the various means at their disposal to express their views. *Vis-a-vis* the vitally important health proposal, it is obviously desirable that many of those who express opinion are physicians.

Without belaboring the point, since doctors of medicine are by no means a majority of the general population, and since health legislation increasingly interests more and more people, the absolute NECESSITY for physician liaison with lawmakers is all too clear. All of the physicians in a community may concur in the inadvisability of a proposed health law, may discuss it among themselves at medical meetings, in the hospitals and in chance social gatherings — but they will have no impact whatsoever on the State Legislature unless they convey their views to their elected representatives. Meanwhile, a mere 5% of the general community (which may numerically outnumber the physicians ten to one) may actually be importuning those representatives to PASS that objectionable law.

SINCE THE LEGISLATOR'S job is to represent, to the best of his ability, all of the people of his constituency he is not to be faulted if he does not have the opportunity to weigh the views of those who are really best qualified to advise him. Neither is he to be faulted for failure to seek out professional opinion, for he has not one or two, but perhaps hundreds of proposed bills on scores of subjects to consider.

LOBBYING

The Michigan State Medical Society employs staff personnel to act as an operating arm of the Society's Legal Affairs Committee which, in turn, is advisory to The MSMS Council. A "lobbyist" is one who is paid to legislatively represent a group or a position. In the case of proposed health legislation, the members of the State Legislature WILL hear from MSMS' representatives in Lansing and, as the exception rather than the rule, they will also hear supporting, or sometimes conflicting, views from a large number of "lobbyists" who represent other health-related groups, other professions and other organizations.

"Lobbyists" are essential to the legislative process, a fact now universally accepted. Their activity is legally recognized and legally regulated, and for the most part is carried on forthrightly and respectably. They are frequently recognized by lawmakers as experts in the particular area of interest of their employers, and THEY are frequently sought out by members of the Legislature for technical information. They must, if they are to be effective at all, have a reputation for honesty and dependability.

The "lobbyist," moreover, exercises effectiveness dependent upon the reputation and expertise of his employer. Since the medical profession indeed enjoys the very highest order of respect, its representatives in the Legislature are privileged to benefit from the high regard in which lawmakers hold their employers.

No lawmaker in Lansing would PREFER to receive his information on a technical medical matter from the "lobbyist" rather than from his constituent physicians back home. If he does not have an open channel of personal communications with doctors of medicine, however, there is still an avenue open to him in his workshop in Lansing to ascertain medical opinion. The "lobbyist" WILL seek him out, and alert him to matters of great interest to the medical profession.

Thus there are two mechanisms simultaneously in operation, each of which complements the other — day-to-day representation in the Capitol itself by the "lobbyist," and person-to-person contact between physicians and their own legislators in both the home areas and the Capitol itself. Neither is a substitute for the other, and between the two it is the latter which is indispensable.

WE CAN, AND DO, ALL HELP MAKE OUR LAWS — and we have a very real choice in outcomes. We can help to make them good ones by realizing that our elected representatives ARE accessible and DO welcome constructive contact. We can all help to make our laws bad ones by simply not participating in the process.

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Let's Abolish Criminal Insanity

BY STATE REP. ROY SMITH, CHAIRMAN,
SPECIAL COMMITTEE ON MENTAL HEALTH
LEGISLATION FOR CRIMINAL CASES
OF YPSILANTI

The theory that the insane person should not be held responsible for his crimes, that "the madman is punished by his madness alone," appears to be universally regarded, by lawyers and laymen alike, as one of the great enlightened principles upon which our system of justice is based.

As a layman who has recently, in conducting an extensive legislative study, been privileged to discuss related specific questions with some of the best psychiatric and legal authorities available, I question this age-old, time-honored theory, for two reasons:

First, I see little evidence, in either our laws or the level of financial support we give our mental institutions, that we have ever really believed this principle.

Second, even if we did believe it, I wonder if this theory isn't inherently unworkable?

LET'S LOOK, FOR EXAMPLE, at the plea and verdict of "not guilty by reason of insanity." The best-known example I could cite of the popular concept of how this verdict works would be the novel *Anatomy of a Murder,* which was written by a former Michigan Supreme Court Justice, under the pen-name of Robert Traver. Most everyone who read that great best-seller of 1958, or saw the Otto Preminger movie made from it, was probably left with warmly-renewed faith in our legal system.

In this story, it may be remembered, a cool-mannered Army lieutenant killed the man who had raped his wife, then insisted in court that he could remember nothing of the shooting. Considerable doubt was cast on his story, but this didn't matter. The jury, like the reader, wanted to see the lieutenant acquitted. And the insanity verdict by offering a means of freeing him proved its wonderful and enduring value, even if occasionally misused.

Although reportedly based upon an actual case, there is one troublesome flaw in the picture painted by this story: under a Michigan statute that was repealed only in 1966 (P.A. 175 of 1927, Sec. 766.15C), any person found not guilty of murder by reason of insanity had to be committed to an institution for the criminally insane — not until found to be sane but, unless a governor intervened, *for the remainder of his natural life!*

MEANWHILE, THE AVERAGE person found *guilty* of murder appears to have been serving about 15 years in prison.

If the kindly old judge in *Anatomy of a Murder* had followed the law, as real-life judges generally do, the lieutenant would not have been freed. Instead, he'd have stayed on in a county jail for months, waiting for overcrowded Ionia State Hospital to admit him. His first glimpse of his future home would probably be somewhat reassuring; he'd see no fence or wall around the buildings, nothing to suggest a prison.

Once inside, though, he'd soon wish there was a wall. When hospitals are forced to serve as custodial institutions, a certain price has to be paid. Wherever the lieutenant went, from the oppressive monotony of the wards to the rushed schedule and ear-splitting din of the big barn-like dining-room, he'd move through portions of the seemingly endless tunnels that honeycomb the place.

Even on a mere tour of Ionia, an official Medical Audit Committee reported after a 1965 study, "one begins to feel somewhat like a mole."

Because of a shortage of both linens and clothing, the lieutenant would have been allowed to take just one shower a week, or two showers if he performed manual labor. To add to the smell of sweat in his crowded ward at night, he'd have been forced to use what is politely termed a "chamber pot," for which no cover was provided.

All of which, as the Audit Committee noted, "results in quite an odorous situation . . . since ventilation is a problem in some areas."

Still, the lieutenant would have found the most unbearable aspect of his confinement to be sheer monotony. "The absolutely apathetic, empty existence that these men lead on the wards and the groping efforts which they follow to busy themselves with nothing is terrible to behold," the Audit Committee reported. And the House Men-

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The author, Representative Roy Smith, of Ypsilanti, has been chairman of a special committee of the Michigan House of Representatives to study mental health legislation for criminal cases. Representative Smith, a graduate of the University of Michigan and a former Ypsilanti Township supervisor, was first elected to the Michigan House in 1966.

tal Health Committee, conducting its own study, concluded that "Hopelessness is more apparent than treatment."

IT IS NOT MY PURPOSE to condemn Ionia State Hospital, where conditions have been improved in the last two years, and which is in the process of being phased out as a special institution for the criminally insane anyway. Conditions would have been far more unbearable in 1965, the Audit Committee noted, except for the constant and determined efforts of a number of dedicated staff members.

Moreover, the place where Michigan has been confining its criminally insane was no worse than St. Elizabeth's in the District of Columbia or Matteawan in New York State, and all three are better than most such institutions in this nation. As one professor of psychiatry, Dr. Emanuel Tanay of Wayne State University, writes me, "The hospitals for the criminally insane across the country are neither hospitals nor jails, but combine the worst of both!"

This nation spends an average of $6.30 a day on inmates of its public mental institutions — in an era when any semblance of true psychiatric care in a private hospital runs at least $50 a day. As a result, according to one nationally-known legal expert, Professor B. J. George, Jr. of the University of Michigan, confinement in such institutions "is difficult to distinguish from penitentiary imprisonment, except that the penitentiary is likely to offer more rehabilitation services than the mental institution!"

IN LIGHT OF THIS, and in light of the fact that the special institutions for the criminally insane have almost invariably been the oldest, most remote, and least desirable of our mental hospitals, can we really go on pretending that we are relieving the insane of criminal responsibility, that we are allowing the "madman" who is charged with a crime to be punished by his madness alone?

AUTHOR
REP. ROY SMITH

Most often, we deny such persons their day in court by ruling them "mentally incompetent to stand trial." In other cases, we grant them a trial and find them "not guilty by reason of insanity" — a verdict that has the practical effect of meaning "guilty and insane." The end product of both procedures is that we punish the "madman" doubly — by confining him indefinitely rather than for a specified term, and by confining him in a place that is generally no better than prison and is frequently worse. Then we doubly damn him by branding him "criminally insane!"

Most of the patients of Ionia, and at New York's Matteawan and other such institutions were committed as "incompetent to stand trial" — which means their confinement resulted neither from having been convicted of a crime nor having been ruled insane in the formal hearing of a civil commitment procedure. In other words, it would be no exaggeration to say that most of our so-called "criminally insane" have not formally been ruled either criminal or insane by any semblance of due process of law.

Dr. Ames Robey, who heads Michigan's new Center for Forensic Psychiatry, has made an extensive study of the question of incompetency and has asserted, in the *American Journal of Psychiatry,* that the widespread misuse of this procedure "represents the grossest violation of an individual's rights." Yet if past precedence is any guide, as another study, made at Ionia, summarized its statistics in the same *Journal,* "well over half the individuals committed as incompetent to stand trial will spend the rest of their lives confined!"

I ASK AGAIN, CAN WE really claim the "madman" we charge with a crime is being punished by his madness alone? Since 1939, we have had, in Michigan, a law I hope to see repealed in the current Legislative session — a "criminal sexual psychopath" statute providing for the commitment of certain persons charged with or convicted of sex crimes. In examining the workings of this law, a Governor's study commission discovered that, as a rule, the major and violent sex offenders were being sent to prison while the minor or nuisance offenders were being committed to a mental institution. Yet the same study showed that the sex criminal imprisoned at Jackson was twice as likely to be paroled, within any given number of years, as the offender committed to Ionia!

I make no claim to either legal or psychiatric expertise. But to my layman's mind, we have a "gray area" in our system of justice — a zone where our courtroom procedures are not really criminal or civil in nature, where confined persons are not really patients or prisoners, and where places of confinement, as Dr. Tanay put it, "are neither hospitals nor jails." And in my layman's opinion, this gray area exists only because we are stubbornly refusing to face up to one very basic question:

HOW, IF INSANITY RENDERS a person not guilty of crime, can anyone possibly be "criminally insane?"

The word "insanity" has no real medical meaning. Psychiatrists refer to it as "a vague legal term for mental illness." Courts define it only by means of statutory "tests." Originally, for example, there was the old English M'Naghten Rule: Did the accused know right from wrong? At present, the Durham Rule is used in some jurisdictions: Was the crime a "product" of mental illness? Still another test, recently proposed for Michigan, read as follows: Was the accused, at the time he acted, incapable, by reason of mental disorder or defect, of conforming his conduct to the requirements of the law?

Such semantic gymnastics could be performed indefinitely. But Dr. Alexander Dukay, who heads Ypsilanti State Hospital, has expressed doubts to me that any statutory test for substantive insanity will ever really prove satisfactory. All such tests ask a question that can seldom really be answered yes or no. In actual practice, in fact, the question is usually answered both ways; both the defense and the prosecution generally manage to find psychiatrists to support their respective arguments.

The very concept of a legal test for insanity in a criminal case, it seems to me, is based upon the highly questionable assumption that we can invariably draw a line between a non-responsible group for whom commitment is indicated, and a blackhearted bunch who deserve to go to prison.

Even if we were living up to that assumption by providing the insane with conditions of confinement far preferable to those offered convicts — and we are not — the assumption would still be highly questionable. I think I can safely assert that even the most hopelessly psychotic person generally retains some measure of volition or choice. And after discussions with such experts as Dr. Andrew Watson, who has the rare distinction of being a professor of both psychiatry and law at the University of Michigan, I feel similarly secure in asserting that most criminal acts are at least partially the product of some degree of mental disability. The sharp, clear dividing line demanded by the statutory tests for substantive insanity simply doesn't exist.

I THINK MICHIGAN HAS moved far ahead of most states toward recognizing this fact. In addition to initiating the phasing out of Ionia as a special institution for the criminally insane, the 1966 Legislature made many statutory gains — including a new law covering mental incompetence that probably provides more safeguards than any other in the nation today.

I hope the present year will see Michigan making a definite beginning on the construction of a proposed new "twin" facility, where the departments of Mental Health and Corrections can work cooperatively and yet in their separate fields of expertise, providing competent treatment in a setting of secure custody for both mentally ill convicts and mental patients who present security problems.

The day when psychiatric treatment will be regarded as a major and indispensable part of prison rehabilitation efforts, with adequate financial support, may be far in the future. I do not propose, no matter how extensive past abuses have been, that we can eliminate the major commitment procedures that occur in our criminal courts — incompetency-to-stand-trial rulings, and not-guilty-by-reason-of-insanity verdicts.

I do suggest, however, that the time has come for us to recognize clearly that our public mental hospitals are medical and not custodial institutions, that the very dedicated psychiatrists who staff them are doctors and not wardens, and that we have no right to make them responsible for the confinement of any individual except for the purpose of providing care and treatment. In other words, we must stop burdening our Department of Mental Health with persons who are more properly subjects for conventional criminal sentencing.

WITH THE ADVANCES made in 1966, Michigan has reached the point where the entire contradictory concept of the so-called "criminally insane," including such resulting designations as "criminal sexual psychopath," can be erased from the lawbooks and the language alike, and patients in our mental hospitals can be regarded solely as sick people, without criminal stigma to discourage recovery. If repeal of the outdated criminal sexual psychopath act can be achieved this year, in fact, the remaining task will be more one of education and adequate financing than statutory change.

Only when we stop looking upon our mental institutions as an auxiliary prison system can we really claim to be relieving the insane of criminal responsibility. Both the laws and the living conditions with which we have been doubly punishing "madmen" are the products of our pretensions. I urge only that we discard those pretensions.

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Nixon's Views on Medical Issues

Richard M. Nixon will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues: —

FEDERAL ROLE IN MEDICINE

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

MEDICARE

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a re-examination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

MEDICAID

I favor the basic philosophy of medicaid — that of helping medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations . . . .

What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

NATIONAL COMPULSORY HEALTH INSURANCE

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need . . . .

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

COMPULSORY AREAWIDE HEALTH PLANNING

I oppose compulsory areawide health planning. We can't assure communities better health planning just by making such groups compulsory. Areawide planning should be left to state and local determination.

FEDERAL CONTROL OF PHYSICIAN'S FEES

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

DEPARTMENT OF HEALTH

As President, I intend to establish a Commission on Government Reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

MENTAL HEALTH

We must develop new methods of treating the mentally ill . . . .

TAX DEDUCTIONS FOR THE AGED

The 100 percent income tax deduction for nonreimbursable drug and medical expenses of those over 65 should be restored.

PREVENTIVE MEDICINE

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.

Automated mass screening programs would seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

HILL-BURTON ACT

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered.

ABORTION LAWS

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state . . . . I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state — a majority of people of the state — reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered.

SIDE EFFECT

A drug is a substance which, if injected into an animal, produces a paper.

—Otto Loewi, Ph.D., *quoted in IBM Think*

IRON MOUNTAIN SALUTES NATIVE ON COLUMBIA STAFF

William B. Seaman, M.D., chairman of the radiology department of the Columbia University College of Physicians and Surgeons, recently returned to his home town of Iron Mountain for a "Native Son Appreciation Day" celebration in his honor.

Three local doctors were speakers at the dinner program sponsored by the Rotary Club and attended by several hundred citizens of Iron Mountain. John Newkirk, M.D., W. H. Huron, M.D., and Donald Anderson, M.D., described Dr. Seaman's early life and professional career.

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Midwest Health Care Conference Proposes Many Suggestions

BY VERNON V. BASS, M.D.,
SAGINAW, VICE-SPEAKER OF
MSMS HOUSE OF DELEGATES

The recent midwest Conference on Health Care offered a number of suggestions which might prove helpful to medicine, hospitals, business, government and other segments concerned with the subject.

The Secretary of HEW sponsored a Regional Conference on Health Care Costs recently in Cleveland. Twenty-four representatives of the medical professions, hospitals, insurance, labor, nursing, and public health attended from Michigan.

Many of the comments are worth reporting and interpreting for MSMS members; and it must be recognized that such possible articles could take many different approaches.

HEW Secretary Cohen set the tempo for the conference with this quotation:

"The Conference has been designed to bring together the leaders of the health community and the insurance industry, consumers and purchasers, (both government and private) to approach the problem of rising health care costs through the stimulation of experiments and innovations in the organization and delivery of health care services, as they relate to state and local communities."

THE OPENING ADDRESS by George Bugbee, director, Center for Health Administration Studies, University of Chicago, who expressed serious concern about rising costs, technological changes, inflation, hospital payrolls, MDs fees, and a hope for innovative ideas at the local community to halt rising costs.

Arthur E. Hess, Deputy Commissioner, Social Security Administration, then described problems "to promote and emphasize voluntary effort and action." He said, "local control often means no control and no planning." He asked the participants to "explore the public and private policy of providing health care so that the consumer can get dollar value." He emphasized the importance of health care delivery and "the judicious combination of peer groups and incentive formulas and methods to provide better efficiency in the delivery of health care."

The conference participants met in discussion groups and then presented observations and recommendations.

Representing MSMS at the Midwest Conference were Vernon V. Bass, M.D., Saginaw, Vice-Speaker, MSMS House of Delegates; Robert E. Rice, M.D., Greenville, Chairman, MSMS Committee on Rural Medical Services, and also Herbert Mehler, of the MSMS Staff.

THERE WAS CONSIDERABLE discussion about hospital costs. It was recognized that "with about 75% of hospital cost going for personnel, how real is the cost control that the physician can exert?"

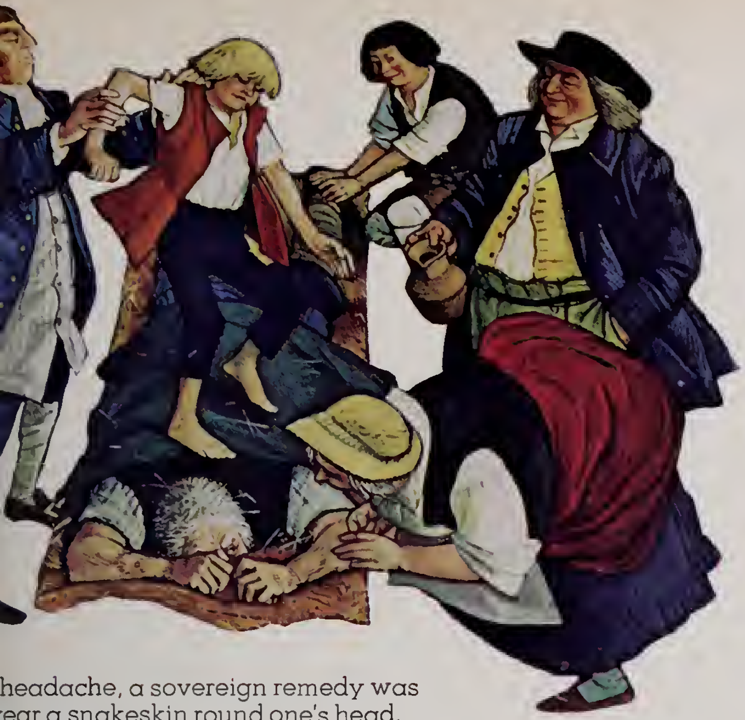
The most effective system of cost control, it was suggested, will come through a partnership effort, whereby the board, the administration, the medical staff, and other staff are collaboratively engaged in reaching the dual objectives of (1) quality service to the patient, and (2) control of costs. Cost control is achieved by a variety of means, such as non-duplication of expensive equipment, fullest possible use of facilities, wise deployment of personnel, rendering of services by the most efficient means, etc.

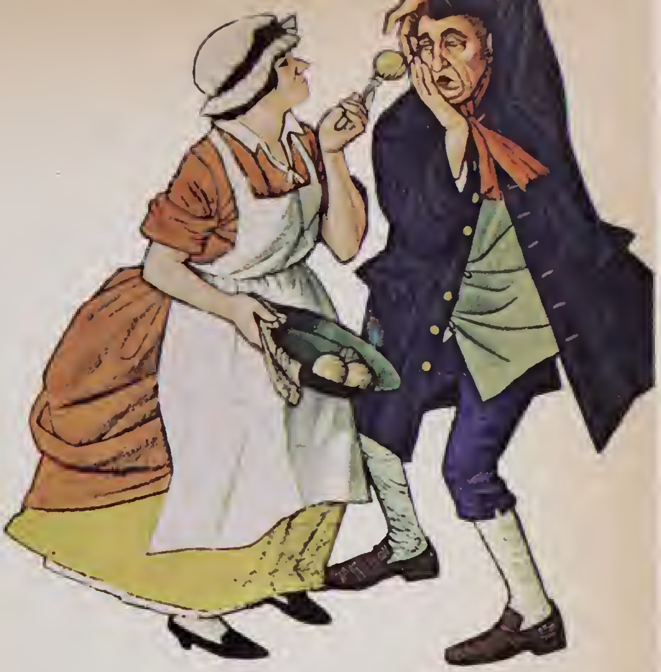
As a means to achieve this partnership effort, it was proposed that:

a. Physicians serve on the governing boards of hospitals with the same privileges as other board members;
b. Hospital medical staffs be given the opportunity to select their representatives to the board, be careful in the selection, and see that there is provision for continuity on the board;
c. Opportunities be provided whereby administration and medical staff, and other staff, get together to explore and work out more effective ways to achieve common objectives, especially the objective of quality patient care coupled with cost control.

(Continued on 1527)

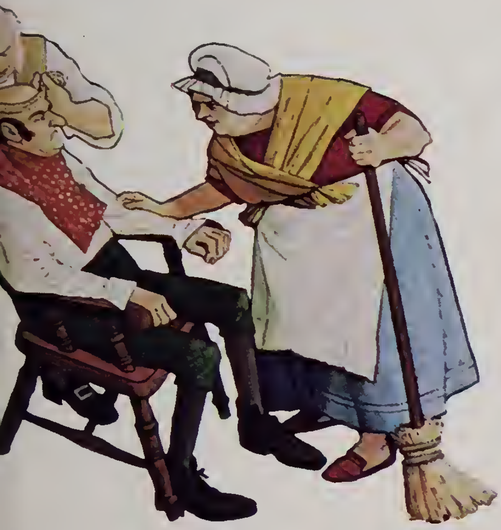
nce-popular treatment for back pains
s to have the seventh son of a seventh son
nd or walk on the patient's back.





The pain of earache was allegedly relieved
by holding a hot roasted onion to the ear.

headache, a sovereign remedy was
ear a snakeskin round one's head.



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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

350-8

MIDWEST HEALTH CONFERENCE/Continued

Many, many needs were expressed in the reports from the discussion group. These included:

1. Simplify paper work in Medicare-Medicaid
2. Use medical students in doctors' offices
3. Education of consumer to conserve health
4. Medical schools should provide medical economic courses for medical doctors
5. More use in ECF's of home care services
6. Improve productivity through better management
7. Commercial carriers should have more rapport with medical societies
8. Funding to facilitate use of more medical advertising and marketing to advise people of available health services
9. Improve recordkeeping — need for data banks
10. Centralization of emergency and weekend services
11. More use of lower level para-medical personnel
12. Further standardization of nomenclature and coding
13. Education of the consumer to keep costs down
14. Education of consumer that medical care is not free
15. Immediate expansion of medical schools
16. More use of para-medical personnel before MD sees patient

Many materials were distributed to the conference participants. Copies are available for interested MSMS members who write MSMS, 120 West Saginaw, East Lansing 48823, for any of the following:

The following material is available on request:

1. "A Health Screening Program for the Inner City: — Flanner House of Indianapolis
2. "Community Health Foundations" — Cleveland, Ohio
3. "Controlled Charges, Reimbursement and Hospital Costs" — Indiana Hospital Association, Indianapolis, Indiana
4. "Expanding Community Hospital Services: Progressive Patient Care" — presented by Robert DeVries, McPherson Community Health Center, Howell, Mich.
5. "Illinois Study Committee on Nursing (ISCON)"
6. "Comparable Costs and Economic Feasibility of the Illinois Zone Mental Health Program" — Illinois Department of Mental Health
7. "Responsibilities of Private Insurer for Experimentation with Methods of Providing Health Care" — Nationwide Insurance Company, Columbus, Ohio
8. "San Joaquin Foundation for Medical Care Prepayment Pilot Project"
9. "Selected Activities of the Chicago Hospital Council Relating to Quality of Care and Cost of Care," Chicago Hospital Council.
10. "Shared Computer Program," Mt. Sinai Hospital, Milwaukee, Wisconsin.

BOOKLETS SUGGESTED TO HELP PLAN HEALTH EDUCATION EFFORTS

Public Affairs Committee booklets on many social and health problems are available to help physicians and county medical societies develop projects, speeches, TV and radio programs, etc., in many areas of current concern.

The Public Affairs Committee is a nonpartisan, non-profit organization in New York, which was founded in 1935 "to help educate the American public on vital economic and social problems."

A note to the Committee can request a copy of their current catalog, or can help interested physicians obtain specific booklets for 25 cents each.

SMOKING-HEALTH

"Smoking, the Great Dilemma," pamphlet no. 361.

"It's Not Too Late to Stop Smoking Cigarettes," no. 386.

"Cigarettes and Health," no. 220A.

SEX EDUCATION

"How to Tell Your Child About Sex," no. 149.

"Sex and Our Society," no. 366.

OTHER TOPICS

"The Negro in America," no. 95.

"The Delinquent and the Law," no. 337.

"What We Can Do About Drug Abuse," no. 390.

"Fads, Myths, Quacks — and Your Health," no. 415.

Mailing address for the Public Affairs Committee is 381 Park Avenue, South; New York, New York 10016.

> "No physician insofar as he is a physician, considers his own good in what he prescribes, but the good of his patients; for a true physician is also a ruler having the human body as a subject, and is not a mere money maker."
>
> — Plato

Michigan Pharmacy Spokesman Asks His Members, "What's Ahead?"

BY ROBERT C. JOHNSON
EXECUTIVE DIRECTOR
MICHIGAN STATE PHARMACEUTICAL ASSOCIATION
REPRINTED FROM MICHIGAN PHARMACY JOURNAL

We are just four days away from completing another fiscal year, the 85th in the Association's history.

How many of these previous eighty-five years were fraught with critical problems that confronted the profession, I do not know. One thing I am certain of is that the problems and challenges that face us will not diminish in the future. If anything, we can expect an even greater test of our profession's strength and ability in the years ahead.

All too many pharmacists continue to have the opinion that they can go it alone — they do not recognize that the conditions which exist in society today are of such magnitude that no individual can possibly cope with all of them.

IF PHARMACY HAD no professional society to represent it, certainly, one would have to be created today.

Government, for example, would not take the time to consult with each individual pharmacist relative to any program that it intended to initiate — but government will listen to a representative body of the profession. Granted, they may not accept every request or recommendation that the association may propose, but, nevertheless, they will listen and, certainly, it has been our experience that many of our proposals have been acceptable.

Try to think for a moment what the practice of pharmacy might be today if there had been no association to speak in its behalf. Would pharmacy as a profession even exist today?

Pharmacy, even with representation, has been, to a considerable extent, a captive profession — captive of the physicians and captive of the pharmaceutical manufacturers. The right to exercise true professional judgment has been impinged since the demise of the era of compounding. Instead, the pharmacist has been compelled to dispense the manufacturer's brand name of a drug as written by a physician. This has left little opportunity for the pharmacist to utilize his highly skilled professional training.

Pharmacists are growing tired of this captivity — and properly so.

PHARMACISTS ARE beginning to ask

— *With my education, why shouldn't I be playing a more responsible role on the health team?*

— *Why shouldn't I be determining the patient's medication regimen?*

— *With my knowledge of drugs, why shouldn't I be determining the drug or brand of drug that should be prescribed?*

— *Am I not in a position to relieve the physician of certain of his responsibilities that he is finding less time to assume?*

These same questions are beginning to be asked by even those outside of pharmacy. With the changing patterns of health care that are developing, government officials, as well as those more enlightened members of other health professions, are wondering why the pharmacist is not performing certain functions that he is trained for but, because of tradition, are still being performed by the physician.

THESE QUESTIONS MUST BE answered and let me assure you that your professional associations, both APhA and MSPA, are directing their attention to these matters with the hope of finding the solution in the very near future.

All informed individuals will admit that the delivery of health care in this country leaves something to be desired.

Certainly, we do not want to develop a completely socialized system that would deprive the citizen of his right to select his health care providers. At the same time, we want to recognize that health care is not a privilege but a *right* to which everyone is entitled.

As pharmacists and responsible health professionals, we must seek ways by which we can better

Editor's Note:

Today medicine is being buffeted on all sides by experts in the field of medical care. In spite of all the experts, the individual care of patients remains the responsibility only of the physician, on a legal, moral and ethical basis. The very basis of medical care is that of therapeusis (the patient does not care much about diagnosis but is most interested in cure). We wonder if the views expressed by Mr. Johnson represent those of the pharmaceutical profession and how they affect a relationship based on years of progress together. The italicized words are mine and not the author's.—John W. Moses, M.D.

deliver our services to the patient and better serve the total health needs of a community — making certain that every citizen is properly cared for.

COMMUNITY PARTICIPATION NEEDED

For any pharmacist to say that he does not have time to participate in community health programs is an admission that he is shirking his responsibility to society.

For years we have been talking about our individual responsibility to the profession which by now, I trust, is well accepted by everyone. I think *now* is the time we must place our emphasis on our responsibility to society.

Society has provided us with our education and with the opportunity to practice our profession. We then must return to society all that we can possibly give to provide a better, healthier environment in which to live.

Certainly, this is a sick world — one that needs the attention of those who can heal — heal by virtue of treating illness as well as conditions.

With crime and violence in our streets, assassination of our leaders, rejection of law and order, abuse of drugs and other maladies, we must turn to those who can heal and seek their help. Is not the pharmacist one who can be turned to? Is he not often the one looked up to in his community?

IT WOULD SEEM THAT the pharmacist, as a respected member of his community, could — if he would — influence in some way the conditions that exist surrounding his place of practice.

If he would become more involved with the youth of his area, trying to understand their problems and reasons for unrest, he might be able to help them find their rightful place in society.

In addition to treating the physical ills of mankind, we must also treat the social ills, for often one is dependent on the other.

Couldn't the pharmacist organize a group in his community that could direct their attention to improving the community, assisting those who need help both physically and materially?

Just in the health area, pharmacists could perform valuable services helping to educate the young about drug abuse, venereal disease, alcoholism, malnutrition and the ways to overcome these problems.

Greater emphasis must be directed toward preventive medicine — and here, certainly, the pharmacist can play an important role.

All too often, pharmacists' only concern about OEO centers and other government sponsored programs is with the prescriptions or possible loss thereof. There is, however, more to consider than the mere dispensation of the prescription. Unless we consider these other responsibilities, there may be little opportunity to ensure the use of private practice in rendering pharmaceutical care.

WE HAVE TALKED ABOUT the pharmacy being a health information center — but we must do more than that. Those who most require health information are not likely the ones to seek it — instead, they must be sought out. The pharmacist cannot do this unless he leaves the comfort of his prescription department and goes out into the streets to examine the conditions and find those who need care. He must then see that they receive proper medical attention.

These are the things we are talking about when we speak of comprehensive health care. If we reject government providing such care through OEO centers, etc., then we, as responsible citizens and health professionals, must substitute in its place our own time and interest.

Perhaps if we treat the physical ills of our society, the social ills will become lessened.

PHARMACISTS OF THE FUTURE

This leads us to a consideration of the future role of the pharmacist. For anyone who thinks we can preserve the status quo — I am afraid he, like Rip Van Winkle, has been asleep for all too many years.

Society is changing — and changing rapidly. Unless we change along with it, we will be left so far behind that our contemporaries will soon forget who we were.

Some pharmacists reject the theories proposed by Dr. Goddard and others who maintain that the pharmacy of tomorrow will be somewhat different from today.

It is an exciting experience to live through a revolution, but it is a regretful experience to live through one and not know it is taking place.

I am afraid all too many pharmacists are suffering through a regretful experience. They do not see the changes that are taking place — because it is easier not to.

As long as there are prescriptions to be dispensed and money is coming in, it is easier to not concern ourselves with how much longer this will last.

THERE ARE THOSE, however, who do recognize that the pharmacist of the future, because of the pressures of society and the ever-changing world, will be practicing his profession within the next two or three decades in a different manner than he is today. At this time, I am participating, along with eleven others from across the nation, in a study designed to determine the future "pharmacist." This research project will consider his educational experience, his environment, and his professional responsibilities.

I am not certain of what the pharmacist of the future will be, but I do know he will resemble something different from what he is today.

There have been enough significant changes in the delivery of pharmacy care in this past decade to convince me that this is only the beginning. We are only on the threshold of finding what our future role will be and how it will be performed.

THINK ALONG WITH ME, if you will,
— about the impact that prefabricated medicine has had on our profession —

— about the changes in our educational requirements —

— about the involvement of government in our profession —

— about the degree of specialization and sophistication in medical care.

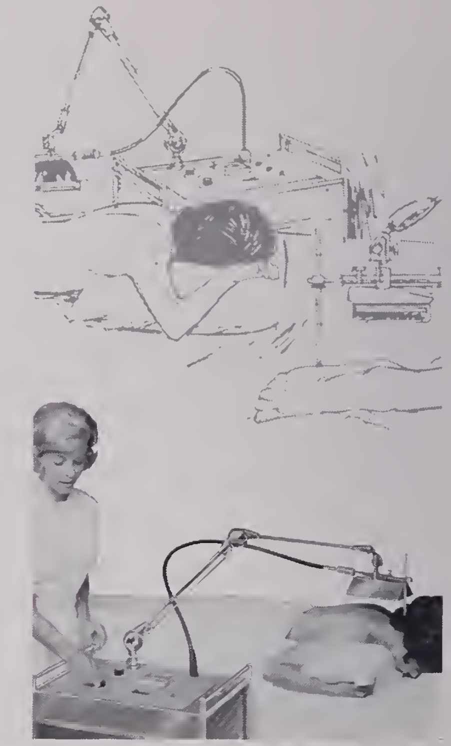
In how short a span has this occurred? Then tell me if we are not witnessing a resolution in the concepts and delivery of health care.

Can you envision the future? I can't entirely, but I have some ideas. I would be interested in your thoughts. If we can think about the change that is occurring and plan for it, it might be more palatable and easier to accept.

Again, we need to recognize that as individuals, survival will be difficult. But as one aggregate working through a strong, progressive professional association, we can not only survive but become strengthened and perhaps even more useful to our society.

So long as I have the privilege of serving you, I will work toward this end.

With your support and the support that you can engender from others, I am confident we will have a bright future.



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MSMS members, when they are in Chicago, are cordially invited to visit the AMA Headquarters at 535 N. Dearborn.

Last year, nearly 900 persons toured the AMA building. The AMA extends a warm welcome to all physicians, their wives and guests to take a 40-minute tour to become better acquainted with the AMA's organizational structure, its major areas of activity and some of the numerous services available to physicians, as well as the public. Tours are given between 9:00 a.m. and 4:00 p.m., Monday through Friday.

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National Report Suggests Ways "to Save the Cities"

What future do the cities in Michigan and the nation face?

Every MSMS member is concerned with this question and many physicians are working actively on city councils, school boards, zoning agencies, planning commissions and other official bodies to help seek solutions.

The Report of the National Advisory Commission on Civil Disorders evaluates problems and possible courses of action. Following are some direct quotations to help MSMS better understand changing conditions and the recommended steps toward solutions.

THE REPORT CONTENDS that "the only possible choice for America to save the cities is to pursue integration by combining ghetto enrichment with policies which will encourage Negro movement out of central city areas."

"By 1985, the Negro population in central cities is expected to increase by 72 percent to approximately 20.8 million. Coupled with the continued exodus of white families to the suburbs, this growth will produce majority Negro populations in many of the nation's largest cities.

"The future of these cities, and of their burgeoning Negro populations, is grim. Most new employment opportunities are being created in suburbs and outlying areas. This trend will continue unless important changes in public policy are made.

"In prospect, therefore, is further deterioration of already inadequate municipal tax bases in the face of increasing demands for public services, and continuing unemployment and poverty among the urban Negro population.

"Development of a racially integrated society, extraordinarily difficult today, will be virtually impossible when the present black ghetto population of 12.5 million has grown to almost 21 million.

"To continue present policies is to make permanent the division of our country into two societies; one, largely Negro and poor, located in the central

(Continued on 1534)

Many Conditions Involving Negroes "In State of Crisis" Says Report

"Many facts and statistics about the Negroes are contained in the Report of the National Advisory Commission on Civil Disorders, and some of them are repeated below:

"Throughout the 20th Century the Negro population of the United States has been moving steadily from rural areas to urban and from South to North and West. In 1910, 91 percent of the nation's 9.8 million Negroes lived in the South and only 27 percent of American Negroes lived in cities of 2,500 persons or more. Between 1910 and 1966 the total Negro population more than doubled, reaching 21.5 million, and the number living in metropolitan areas rose more than five-fold (from 2.6 million to 14.8 million). The number outside the South rose eleven fold (from 880,000 to 9.7 million).

"Although there have been gains in Negro income nationally, and a decline in the number of Negroes below the "poverty level," the condition of Negroes in the central city remains in a state of crisis. Between 2 and 2.5 million Negroes — 16 to 20 percent of the total Negro population of all central cities — live in squalor and deprivation in ghetto neighborhoods.

"Negro men are more than three times as likely as white men to be in low paying, unskilled or service jobs. This concentration of male Negro

(Continued on 1534)

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an underlying depression.

---

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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

CONTINUED: NATIONAL REPORT SUGGESTS WAYS "TO SAVE THE CITIES"

cities; the other, predominantly white and affluent, located in the suburbs and in outlying areas.

"Equality cannot be achieved under conditions of nearly complete separation. In a country where the economy, and particularly the resources of employment, are predominantly white, a policy of separation can only relegate Negroes to a permanently inferior economic status.

"Enrichment must be an important adjunct to integration, for no matter how ambitious or energetic the program, few Negroes now living in central cities can be quickly integrated. In the meantime, large-scale improvement in the quality of ghetto life is essential.

"But this can be no more than an interim strategy. Programs must be developed which will permit substantial Negro movement out of the ghettos. The primary goal must be a single society, in which every citizen will be free to live and work according to his capabilities and desires, not his color.

"The National Advisory Commission on Civil Disorders Report offers many recommendations, including the following three 'toward the reaction of a true union:'

> "Opening up opportunities to those who are restricted by racial segregation and discrimination, and eliminating all barriers to their choice of jobs, education and housing.
>
> "Removing the frustration of powerlessness among the disadvantaged by providing the means for them to deal with problems that affect their own lives and by increasing the capacity of our public and private institutions to respond to these problems.
>
> "Increasing communication across racial lines to destroy stereo-types, to halt polarization, end distrust and hostility, and create common ground for efforts toward public order and social justice."

Continued: Many Conditions Involving Negroes "In State Of Crisis" Says Report

employment at the lowest end of the occupational scale is the single most important cause of poverty among Negroes.

"In 1966, about 11.9 percent of the nation's whites and 40.6 percent of its non-whites were below the "poverty level" defined by the Social Security Administration (currently $3,335 per year for an urban family of four). Over 40 percent of the non-whites below the poverty level live in the central cities.

"The infant mortality rate for non-white babies under the age of one month is 58 percent higher than for whites; for one to 12 months it is almost three times as high.

"The 500,000 "hard-core" unemployed in the central cities who lack a basic education and are unable to hold a steady job are made up in large part of Negro males between the ages of 18 and 25. In the riot cities which we surveyed, Negroes were three times as likely as whites to hold unskilled jobs, which are often part time, seasonal, low-paying and "dead-end."

"Many ghetto residents simply cannot pay the rent necessary to support decent housing. In Detroit, for example, over 40 percent of the non-white occupied units in 1960 required rent of over 35 percent of the tenants' income."

COMING AMA CONVENTIONS

1968: Miami Beach (Dec 1-4)
1969: New York City (July 13-17)
Denver (Nov 30-Dec 3)
1970: Chicago (June 21-25)
Boston (Nov 29-Dec 2)
1971: Atlantic City (June 20-24)
New Orleans (Nov 28-Dec 1)
1972: San Francisco (June 18-22)
Atlanta (Nov 26-29)
1973: New York City (July 15-19)
Anaheim (Nov 25-28)
1974: Chicago (June 16-20)
Portland, Ore (Dec 1-4)

IN MEMORIAM

M. A. Baeff, M.D., Detroit

Michael A. Baeff, M.D., retired Detroit physician, died October 13 at the age of 85.

Born in Russia, Doctor Baeff received his medical degree from the Moscow University Medical School in 1911. From 1911 to 1923 he served in the medical military service of the Russian army.

He moved to Detroit in 1923 and joined the staff of the Rouge Hospital at the Ford Motor Company plant in Dearborn, where he was employed until his retirement in 1949.

Doctor Baeff was the founder of the Russian-American Club of Detroit.

D. J. Carothers, Jr., M.D., Charlotte

Daniel J. Carothers, Jr., M.D., Charlotte physician and surgeon, died October 25. He was 57.

Doctor Carothers had practiced in Charlotte for 22 years and was a past president of the Eaton County Medical Society.

He was graduated from Ohio Wesleyan University in 1934 and from the Western Reserve University Medical School in 1938. His internship was at Cleveland City Hospital, 1938-39. He did a residency in obstetrics and gynecology at Cleveland City Hospital, 1939-40, and was chief resident in surgery at Lutheran Hospital, Cleveland, Ohio, from 1946-47.

A flight surgeon in World War II, he received the Bronze Star for service in the South Pacific.

Doctor Carothers was a Fellow of the American College of Surgeons and a member of Alpha Kappa Kappa.

S. G. Delbert, M.D., Kalamazoo

Stewart G. Delbert, M.D., Kalamazoo general practitioner, died November 11, at the age of 59.

Doctor Delbert received the M.D. degree from the Wayne State University School of Medicine in 1941. His pre-medical education was at Michigan State University and Wayne State University.

From 1941-45 he was a member of the Army Medical Corps. Following the war, he served continuously in the Army Reserves and was a member of the Reserve Officers Association and the American Legion.

He was affiliated with Borgess Hospital and Bronson Methodist Hospital in Kalamazoo.

R. J. DeMol, M.D., Grand Rapids

Richard J. DeMol, M.D., Grand Rapids, the Michigan Hemophilia Foundation's Doctor of the Year in 1966, died November 12. He was 65.

Doctor DeMol was honored by the Michigan Chapter of the National Hemophilia Foundation when he was selected Doctor of the Year for his dedicated care of a hemophilic patient. The award was presented to Doctor DeMol during the MSMS Annual Session in Grand Rapids in 1966.

He held an A.B. degree from Calvin College in Grand Rapids and received the M.D. degree from the Northwestern Medical School, Illinois, in 1930. He was affiliated with Blodgett Hospital in Grand Rapids and was on the courtesy staff of Butterworth and St. Mary's Hospitals.

Doctor DeMol was a member of the Academy of General Practice and the Chamber of Commerce.

L. C. Dickson, M.D., Detroit

Laurie C. Dickson, M.D., Detroit internist, died October 6 at the age of 47.

Doctor Dickson was graduated in 1943 from the Johns Hopkins University School of Medicine, Baltimore, Maryland. He served as a captain in the Army Medical Corps from 1946-48.

He was a member of staff at Henry Ford Hospital, Detroit, since 1950.

Doctor Dickson was a member of the American Society of Internal Medicine and an associate of the American College of Surgeons. His medical fraternity was Phi Chi.

Survivors include his wife, Mary D. Dickson, M.D., who is a practicing physician.

S. L. Loupee, M.D., Dowagiac

A news article about the death of Doctor Loupee appears in this issue on Page 1484.

R. A. McGarry, M.D., Flint

Roy A. McGarry, M.D., long-time Flint general practitioner, died October 1. He was 80.

Doctor McGarry had practiced in Flint since 1919.

He received the M.D. degree from the University of Michigan Medical School in 1912, and then served as an instructor there for five years. During World War I he was a captain in the Medical Corps.

Doctor McGarry was a Life Member of MSMS, a Fellow of the Academy of International Medicine and a member of the Elks.

J. T. Sample, M.D., Saginaw

John T. Sample, M.D., Saginaw physician for over 50 years, died October 4. He was 85.

Doctor Sample was graduated in 1908 from the University of Michigan Medical School. After a year as a resident at University Hospital, he spent a three-year residency at Johns Hopkins Hospital. From 1912-14 he studied neuropsychiatry and general medicine in Munich and Vienna. He was a member of the U.S. Army Medical Corps from 1916-19, serving part of that time as division psychiatrist.

A Life Member of MSMS, Doctor Sample was a Fellow of the American Psychiatric Association and of the American College of Physicians, and a member of Alpha Omega Alpha, Nu Sigma Nu, and Sigma Xi. He was a member of staff at all three Saginaw medical hospitals.

Doctor Sample was a Past President of the Saginaw County Medical Society, Saginaw Rotary Club and Saginaw Valley Torch Club.

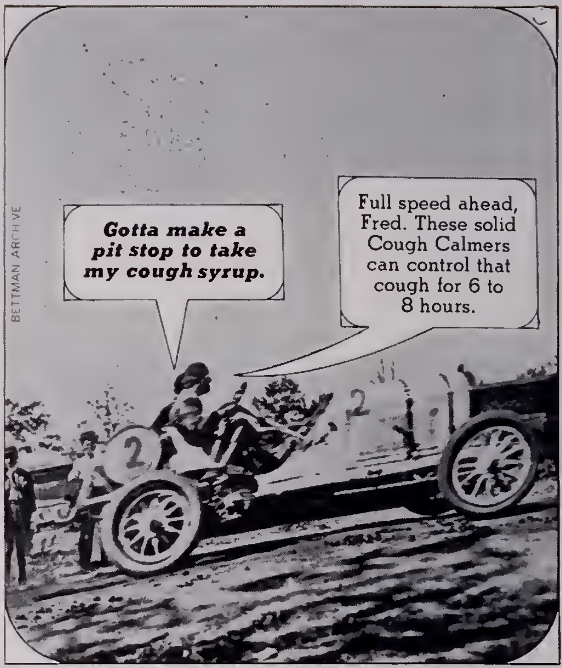
N. M. Ward, M.D., Flint

Nell M. Ward, M.D., Flint physician for 48 years, died November 4. She was 79.

Doctor Ward, born in 1889, was graduated in 1915 from the Woman's Medical College in Pittsburgh, Pennsylvania.

She maintained a general practice with special attention to obstetrics and gynecology. Her hospital affiliations were with McClaren General Hospital and St. Joseph Hospital in Flint.

A Life Member of MSMS, she retired from active practice in 1966.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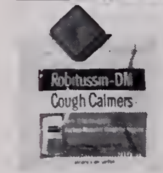

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* 1904 - 1967

Michigan Health Council Observes Silver Anniversary of Service

It was 25 years ago that the Michigan Health Council was founded by the "Big Four in Health Care" — the Michigan State Medical Society, the Michigan Hospital Association, Michigan Hospital Service and Michigan Medical Service.

The officers of these organizations recognized the desirability of comprehensive planning and organized the Council to bring complete health services to all of the people in Michigan through private means and voluntary methods by:

1. Coordinating the efforts of the four founding organizations and other groups interested in the health of the people;

2. Conducting a general education program regarding the advantage to the health of the people to be gained through the private practice of medicine and dentistry, and the operation of voluntary, non-profit hospitals;

3. Taking all necessary and practical steps to arrange for the availability of medical, dental, hospital, and related services.

THE FOUR ORGANIZATIONS did considerable joint comprehensive health planning during the first years of the Michigan Health Council. One of the first was planning a Survey of Michigan Hospitals to determine the scope of hospital services and the availability and distribution of doctors, nurses, and other health manpower throughout the State.

Another important joint effort was a Comprehensive Public Opinion Survey to determine the type of hospital-medical-surgical services that Michigan residents and their employers desired and were willing to pay for under a prepayment program. At the time, only nine percent of Michigan's citizens were covered. As a direct result of the Public Opinion Survey, the most comprehensive prepayment program ever offered was provided Michigan residents; and, within a year, there were more than 1,250,000 subscribers, and the plan became the model for the United States.

About this time, World War II ended and hundreds of thousands of veterans and doctors began returning to Michigan. The Council developed a comprehensive plan to organize community health councils in all areas of Michigan to utilize the professional skills of the returning doctors by building community hospitals and rural medical centers in areas where there was a need. Efforts to organize the community health councils were fruitful, and the prime functions of the new local councils were to:

a. aid in the promotion of better and more adequate health facilities for the community;
b. assist in the development of health information centers;
c. assist in the general development of the health professions and their objectives through coordination, surveys, health education programs, etc.

Upwards of 70 local health councils continue to function today. Some are small and have only one or two major activities, while others are in metropolitan communities with broad membership and projects.

Recognizing the need for involving many more organizations with an interest in health in the Michigan Health Council, the membership of the Council was expanded substantially in 1948 to include the American Cancer Society, the Michigan Tuberculosis Association, the Michigan Heart Association, the Michigan State Nurses Association, the Michigan Farm Bureau, and many other voluntary health agencies as well as the Michigan Department of Health.

Among the efforts of the expanded program were the sponsorship of the Michigan Rural Health Conference and the development of a film showing how community health councils could be effective in rural areas in developing rural medical centers, community hospitals, etc. The Conference gave Michigan farm leaders and farm families an opportunity to sit down with doctors and other health professions to plan new health programs and health care facilities to improve the health of rural families.

Another 15-minute film was produced in cooperation with the Michigan State Medical Society to promote careers in health. A brochure, "Planning Your Career as a Medical Associate," was produced as a companion to the film and has been distributed throughout Michigan. It was the first health career publication of its kind, covering numerous health occupations, and was reprinted by several other states.

In the early 1950s the Brookings Institute selected Michigan as a pilot state in its National

Survey of Health Resources, and the Council's officers, staff and member organizations played a major role in the planning and conducting of this important study. The Council collaborated with the American Medical Association in planning the First National Conference on "M.D. Participation in Health Councils," held in Detroit in October 1950.

In 1951, with special support from the Michigan State Medical Society and the Michigan Heart Association, planning was begun for a state-wide educational program on the importance of "Periodic Health Appraisal Examinations." A new publication, the "MHC Bulletin," was developed to keep Michigan citizens advised on the health news and events of interest to lay and professional people.

The Council embarked on the first health educational television series over WJBK-TV, Channel 2, Detroit. This continued for more than 12 years as the "Court of Health" and later as "Decision" with the Michigan Association of the Professions as co-sponsor.

Similar television series were arranged for Grand Rapids and Cadillac and still are being conducted there. The Council also has received a considerable amount of television time down through the years from other television stations throughout Michigan, particularly from Channel 6, Lansing, on the "Formula" program, sponsored by the Michigan Association of the Professions.

In December 1952 the Michigan State Medical Society invited the Council to establish an M.D. Placement Service. A comprehensive state-wide survey was conducted to determine the need for physicians. With major financial assistance from The Upjohn Company, the Council has developed a program that, for many years, has been considered the most outstanding in the Nation. More than 800 medical doctors have used the program in finding a Michigan community in which to practice. Currently the Council is assisting 126 communities that are in need of family physicians and more than 50 communities that are looking for medical specialists for their communities, their hospitals, public health agencies, industrial medical departments, mental hospitals, student health services, etc.

Recognizing that Michigan offered numerous services from voluntary as well as official health agencies of which the public was not aware, the Council planned a Directory of Michigan Health Organizations. This has proved to be a most useful publication and is published every three years. A recent feature of the Directory is the listing of health, safety and health career films.

In 1954, in cooperation with the National Health Council and the Michigan Department of Health, the Council developed a comprehensive plan for promoting public health units in unorganized areas. A "Citizens Conference on Public Health" was held at the University of Michigan on March 3-4-5, 1954.

In 1957 the Michigan Health Council again substantially increased its membership to 90 organizations and activities. The W. K. Kellogg Foundation approved a plan to develop a Dentist Placement Service, and The Upjohn Company agreed to sponsor the Veterinary Placement Service in addition to the M.D. Placement Program; and the Health Careers Program was greatly expanded.

The Council also served to plan and coordinate another important health program since 1965 — the Michigan Council on Smoking and Health. Sixteen state-wide voluntary and official organizations with a prime interest in eliminating cigarette smoking contribute financially or with staff to the Council. The National Clearinghouse on Smoking and Health has assisted the MCSH during the past two years with a special demonstration grant.

During the past five years, the Council has helped MSMS plan and coordinate Community Health Week.

The Health Council has also had a long-time interest in the elderly. More than 400 senior citizens attended the quackery conference held at Sault Ste. Marie during our 1st Annual Upper Michigan Health Conference in 1965. Quackery also was a feature of our 2nd Upper Michigan Health Congress at Marquette and our 3rd Annual Upper Michigan Health Congress held at Houghton during Michigan Week in 1968.

During the Silver Anniversary Year, the Council's health manpower efforts have been expanded to include the Health Careers Mobile. The Health Careers Mobile, started by MSMS, has been financed entirely through cooperative effort on the part of many voluntary organizations and foundations such as the Michigan State Medical Society, the Sears-Roebuck Foundation, the Michigan

Foundation for Medical and Health Education, Gerber Baby Foods Fund, and the Marlette Homes, Inc.

Through the years there has been a great amount of voluntary health planning going on in Michigan through the Council and its membership. This membership now includes nearly every Michigan United Fund health organization as well as nearly every other voluntary or governmental agency, professional association, college and university, foundation and industry with a major interest in health. This coordination has not required a huge expenditure of private or tax funds, as the planning and programming of the Council have been accomplished with annual budgets ranging from $20,000 to $85,000. Nearly all of the funds have come from grants from member organizations with a minimum from public agencies. Thousands of professional and lay citizens throughout Michigan have donated time to the Council annually.

The past is prologue, and the successes which have been made can best serve as a springboard to keeping Michigan outstanding in planning and providing health services to its present and future citizens.

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Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published Semi-monthly, Tri-monthly in November and December, 26 issues, mailed at Lansing, Michigan in Ingham County for December 1, 1968.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
3. The Publisher is the Michigan State Medical Society. The Scientific Editor is John W. Moses, M.D., 1713 Sunset Blvd., Royal Oak, Michigan 48067; The Managing Editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.
4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
5. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.
6. A. The total number of copies printed averages 7,950 per issue with a single issue nearest to filing date accounting for 7,926 copies.

   B. Paid Circulation:
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   C. Sales to dealers, number none.

   D. Free distribution by mail carrier or other means: 986.

   E. Total number of copies distributed is 7,891.

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Michigan State Medical Society

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Dean Carron, M.D., Ann Arbor, has been appointed by Governor Romney to the State Board of Marriage Counselors for a term ending in June, 1970. Doctor Carron, a psychiatrist, is national director of the Family Service Association of America.

Edmond L. Cooper, M.D., Royal Oak, was a visiting professor of ophthalmology for two days at the University of British Columbia in Vancouver and for a day at the University of Alberta in Edmonton. He also recently addressed the semi-annual meeting of the Arizona Ophthalmological Society on "The A and V pattern: Diagnosis and Treatment" and "The Surgery of Congenital Nystagmus."

Three Battle Creek physicians received certificates of appreciation for 25 years of public service from the National Selective Service. Honored were Roy H. Baribeau, M.D., and Lloyd E. Verity, M.D. The award to Edwin L. Hansen, M.D., was presented posthumously.

Homer Stryker, M.D., Kalamazoo, was the recipient of a presidential citation from the President's Commission on Employment of the Handicapped. The award was presented to Doctor Stryker, orthopedic surgeon and inventor of several orthopedic instruments, at an "Ability Counts Banquet" in Lansing.

Alfred Swanson, M.D., Grand Rapids, was featured in a special documentary television program showing Doctor Swanson at work helping to establish a volunteer medical program to treat Vietnamese civilians. A WOOD-TV photographer accompanied Dr. Swanson on his recent trip to Vietnam — his fifth in the past eight years.

M. S. Brent, M.D., Detroit, has retired from the private practice of medicine to devote more time to the administration of the Brent General Hospital, which he founded more than 25 years ago.

Joseph Scher, M.D., Mt. Clemens, reigned as "King of Football" at the Mt. Clemens Alumni Night football game. That title, an annual tribute to an outstanding man of the community, went this year to Dr. Scher for his devoted service as school and team physician for 33 years.

Douglass Haddock, Jr., M.D., Portage, is the author of an article in the October 28 issue of *Medical Economics* describing a method to set proper charges on the basis of your costs."

Samuel Gershon, M.D., New York City, former U-M Medical School faculty member, has been promoted to professor of psychiatry at New York University School of Medicine, where he is director of the Neuropsychopharmacology Research Unit. He was chief of the schizophrenia and psychopharmacology project at the University of Michigan from 1959-61.

Edwin J. Rennell, M.D., Coldwater, has retired from the position which he held for almost 25 years as medical superintendent of the Coldwater State Home and Training School. Robert A. Wise, M.D., Coldwater, will serve as the new medical director of the Coldwater State Home and Training School. He has been a member of the Coldwater staff since 1959.

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

OLUME 67, NUMBER 25 — DECEMBER 1968 — DEADLINE FOR COPY DECEMBER 10, 1968

Allegan ● Alpena-Alcona-Presque Isle ● Barry ● Bay-Arenac-Iosco ● Berrien ● Branch ● Calhoun ● Cass ● Chippewa-Mackinac ● Clinton ● Delta-Schoolcraft ● Dickinson-Iron ● Eaton ● Genesee ● Gogebic ● Grand Traverse-Leelanau-Benzie ● Gratiot-Isabella-Clare ● Hillsdale ● Houghton-Baraga-Keweenaw ● Huron ● Ingham ● Ionia-Montcalm ● Jackson ● Kalamazoo ● Kent ● Lapeer ● Lenawee ● Livingston ● Luce ● Macomb ● Manistee ● Marquette-Alger ● Mason ● Mecosta-Osceola-Lake ● Menominee ● Midland ● Monroe ● Muskegon ● Newaygo ● North Central ● Northern Michigan ● Oakland ● Oceana ● Ontonagon ● Ottawa ● Saginaw ● St. Clair ● St. Joseph ● Sanilac ● Shiawassee ● Tuscola ● Van Buren ● Washtenaw ● Wayne ● Wexford-Missaukee

MICHIGAN MEDICINE

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Vital Need for Medical Manpower Emphasized Throughout Michigan

Leading citizens across the state are hearing MSMS officials declare that:

"Together, we must more effectively tell all the people of Michigan about the need to educate more physicians in Michigan and then the people must urge their Governor and their elected representatives in the State Legislature to get on with the job.

"If this is done with dispatch, Michigan citizens can be assured of the availability of the first-class medical care that everyone wants — indeed, demands — and which must be provided for them."

That strong statement was made December 12 at Bloomfield Hills at a metropolitan regional meeting of community leaders and officers of the county medical societies in southeastern Michigan by Robert J. Mason, M.D., President-Elect of MSMS.

Doctor Mason, in part, stressed:

"Michigan must carry out a program for health manpower development which makes sense, which is fiscally responsible and which will bring about speedy results. We need to immediately expand the enrollment at the University of Michigan and Wayne State University medical schools and to expand the present two-year medical program at Michigan State University to a four-year, degree-granting program."

Other regional conferences in November and December were held also by MSMS at Grand Rapids and Saginaw to help implement a manpower resolution adopted by the 1968 House of Delegates and a position statement developed by the MSMS Council at its November meeting. MSMS officials at the meetings also have explained the MSMS proposal that the three medical schools offer students the choice of an MD or DO degree, rather than have the state finance a proposed osteopathic school.

Many state and local civic leaders have endorsed the MSMS proposals, and important support has been voiced by the news media.

The Detroit News, in an editorial, declared in part: "It takes mountains of money to build and run a medical school. The money is not yet in sight to develop the U-M and WSU schools to the fullest much less to fulfill the MSU vision of its two-year school expanded to a four-year degree institution. Can the state money the osteopathic boosters acknowledge they need to get anywhere come other than at the expense of these going institutions?" (The full editorial will appear in the January issue of *Michigan Medicine.*)

The Ann Arbor News, in an editorial, suggested, "Let's not throw medical school planning off on the wrong track by elevating osteopathic education to separate institutional basis. The request for full state aid is bound to come. The Legislature should have the wisdom to say no."

The editorial also contended that ". . . if the osteopaths want separate facilities they should finance the college's construction and operations privately, and not seek to pass the costs on to the taxpayers."

The Lansing State Journal editorial page recently said, "It would seem to us that acceptance and implementation of the plan for state-supported joint facilities for training doctors of osteopathy and doctors of medicine would be an important contribution to meeting the urgent need for physicians."

More information about this MSMS public-service effort to arouse the Governor and State Legislature to allocate more funds to educate more physicians in Michigan will appear in the January issue of *Michigan Medicine.*

Ways to help alcoholics employed in industry, to recognize them and refer them to assistance were explored at a recent joint meeting of the Committee on Alcoholism and Drug Dependence and the Committee on Occupational Health. Leaders were Herbert A. Raskin, M.D., at head of table, alcoholism chairman, and William Jend, Jr., M.D., at Doctor Raskin's right, occupational health chairman.

MSU to Study Teaching Skills

Michigan State University's medical school is the recipient of a $125,000 inheritance for its proposal to study techniques of making community physicians more effective teachers of medical students.

The American Medical Association, holding its 22nd annual clinical convention in Miami Beach, presented the sum Dec. 3 to Andrew D. Hunt, Jr., M.D., dean of the College of Human Medicine, fulfilling a bequest of the late Dr. John Snavely of Sterling, Ill.

Dr. Snavely, who died Jan. 15, 1967, willed one-sixth of his estate to be distributed to medical colleges for medical research as determined by the Board of Trustees of the AMA. MSU's proposal was one of six selected for the grant by the AMA.

Through seminars and workshops, MSU plans to prepare materials, such as audio tapes, to teach community physicians to use modern techniques as they instruct MSU students.

"We want to involve community physicians in our program more actively than most schools do," says Hilliard Jason, M.D., director and professor of medical education, research and development in the MSU College of Human Medicine. "Not only do we want them to come to MSU to teach but we also want to send students to their offices, hospitals and emergency rooms around the state. To do this properly we want physicians who can be counted on as effective teachers."

DID YOU PULL MATERNAL HEALTH CARDS FROM JOURNAL?

By James E. Harryman, M.D., Chairman
Committee on Maternal Health

In the December issue of *Michigan Medicine* the accumulated MSMS Maternal Health Desk Cards 1 through 11 were printed. Did you save them?

Originally the Committee on Maternal Health under the chairmanship of Francis Jones, M.D., Lansing, published the "Obstetrical Brevits" in *Michigan Medicine* as its effort toward continuing medical education.

In 1961, under the new chairman William W. Jack, M.D., Grand Rapids, the Maternal Health Desk Cards were the brainchild of Charles M. Bell, M.D., of Grand Rapids. They continued to be produced by him with the aid of the Committee until 1967 when the chairmanship of the sub-committee for Continuing Medical Education was passed to Reinard P. Nanzig, M.D., Grand Rapids, who has been responsible for the updating of the information contained therein.

Symposium Jan. 17-18 on Blood

Donald McKay, M.D., University of California, will be among 20 speakers scheduled for the 17th annual Symposium on Blood Jan. 17-18 at Wayne State University.

Eberhard F. Mammen, M.D., of the WSU Department of Physiology and Pharmacology, one of the conference planners, calls Doctor McKay a "world-renowned authority" on the pathology of Disseminated Intravascular Coagulation, theme of the conference. Doctor McKay's topic will be "Tissue Damage Caused by Disseminated Intravascular Coagulation."

Other speakers scheduled for the symposium are Robert Hardaway, M.D., U.S. Army General Hospital in Frankfurt, who will discuss "Disseminated Intravascular Coagulation in Shock," and Charles C. Owen, M.D., Mayo Clinic, who will talk about "Chronic Intervascular Coagulation Syndromes."

The McGregor Memorial Conference Center at WSU will be headquarters for the meeting. Discussions will cover the clinical, patho-physiological, pathological and therapeutic aspects of disseminated intravascular coagulation and the aspects of disseminated intravascular coagulation in organ transplantation.

Molner Dies; Health Officer, Medical Writer

Joseph G. Molner, M.D., nationally syndicated newspaper columnist and former Detroit and Wayne County Health Commissioner, died Nov. 16 at the age of 61.

His service with Detroit began in 1938, when he became deputy health commissioner. He was made Detroit medical director in 1942 and in 1949 was made city health commissioner.

He became city-county health commissioner in 1958 when the medical posts were merged.

Doctor Molner was a 1935 graduate of Wayne State University Medical College and received a master's degree in public health at Johns Hopkins University. He studied tropical diseases in Central America under the auspices of the Rockefeller Foundation and later taught tropical diseases at Wayne.

Doctor Molner was the author of numerous books and articles in medical journals on communicable diseases and was one of the nation's foremost authorities on polio. For many years he served as medical consultant to the National Foundation for Infantile Paralysis.

Doctor Molner was a former director of the Michigan Public Health Association and one of the founders of the American Board of Preventive Medicine and Public Health.

Genesee Society To Hear Bates

Invitations are out for the annual black-tie dinner scheduled at 7:30 p.m. Jan. 8 by the Genesee County Medical Society. Speaker for the dinner, to be staged at the IMA Annex, Flint, will be Richard C. Bates, M.D., of Lansing.

THOSTESON, AIDE CONTINUE "MOLNER COLUMN"

"To Your Good Health," nationally-syndicated column by the late Joseph G. Molner, M.D., is being continued as a regular newspaper feature. The current authors are George C. Thosteson, M.D., and Jack Pickering, who have been collaborating with Doctor Molner since the column was started in 1952.

Doctor Thosteson, a specialist in internal medicine, will give up his private practice to give full attention to the column. Mr. Pickering, one of the top medical writers in the United States, has helped write the daily copy for "To Your Good Health" for 16 years.

'Tis the Season

The 89 members of the St. Clair County Medical Society's Woman's Auxiliary are again conducting their annual Christmas card sale for the benefit of the AMA-ERF scholarship-loan fund.

For seven years the women have selected greeting card designs relating as closely as possible to the medical field, having them printed by local concerns and offering them for sale to physicians.

Mrs. Claude Ludwig is chairman of this year's volunteer project. Last year's raised $827.

At the recent Hope College convocation honoring South Africa's Christian Barnard, M.D., Ph.D., the MSMS was represented by Executive Director Hugh W. Brenneman, far left. Others pictured, from left, are James L. Poppen, M.D., Ph.D., Chicago neurosurgeon; Doctor Barnard, who received an honorary doctor of science degree; Calvin Vander Werf, Ph.D., Hope College president, and Hugh De Pree, chairman, Hope College Board of Trustees.

USE CHRISTMAS SEALS

A Saginaw County TB Hospital patient, at left, receives encouragement in her fight against the disease by Barbara Cronin of Warren, former TB patient, now Michigan chairman of the TB Christmas Seal campaign, and R. A. Clowater, M.D., medical director of the hospital. Michigan physicians and their wives are helping the Michigan Tuberculosis and Respiratory Disease Association raise $1,632,000 through its current Christmas Seal campaign.

$16 Million in Federal Grants Approved for Detroit Center

Nearly $16 million in federal grants have been approved, though not funded, for the Harper-Webber Medical Center project in Detroit.

The hospital was notified late in November by HEW that the NIH grants were approved. They represent approximately 40 per cent of the $39 million estimated cost of the project.

In addition to the construction of a 348-bed teaching unit, to be known as the Webber Memorial Building, the project includes extensive modernization of Harper's existing buildings. WSU plans to utilize the enlarged hospital as a principal teaching facility for adult medicine and surgery.

The proposed increase in facilities would make it possible for WSU to almost double its student enrollment. Target date for completion of the Webber Building is late 1971, when the WSU Medical School will move to the main campus in the Detroit Medical Center.

ACP Program On Cancer Care Soon at WSU

The American College of Physicians will present a four-day meeting about "The Internist and Total Cancer Care" Jan. 20-24 at McGregor Memorial Community Arts Center, Wayne State University.

Topics to be discussed will include Cancer Detection and Early Diagnosis, Facilities and Resources for Cancer Care, The Internist and Primary Cancer Treatment, Chemotherapy, Endocrine Neoplasms, Leukemia-Lymphoma and Management of Cancer Symptomatology.

"This course is aimed toward preparing internists to meet their responsibilities in total cancer care," according to the sponsors. "A thorough grounding in theoretical principles plus intensive teaching in practical medical oncology will be provided."

Michael J. Brennan, M.D., F.A.C.P., is director of the meeting. He is president, medical and scientific director of the Michigan Cancer Foundation. His co-directors are Robert W. Talley, M.D., F.A.C.P., and Vainutis K. Vaitkevicius, M.D., F.A.C.P.

Registrations are to be forwarded to Edward C. Rosenow, Jr., M.D., F.A.C.P., executive director, American College of Physicians, 4200 Pine St., Philadelphia, Pa., 19104.

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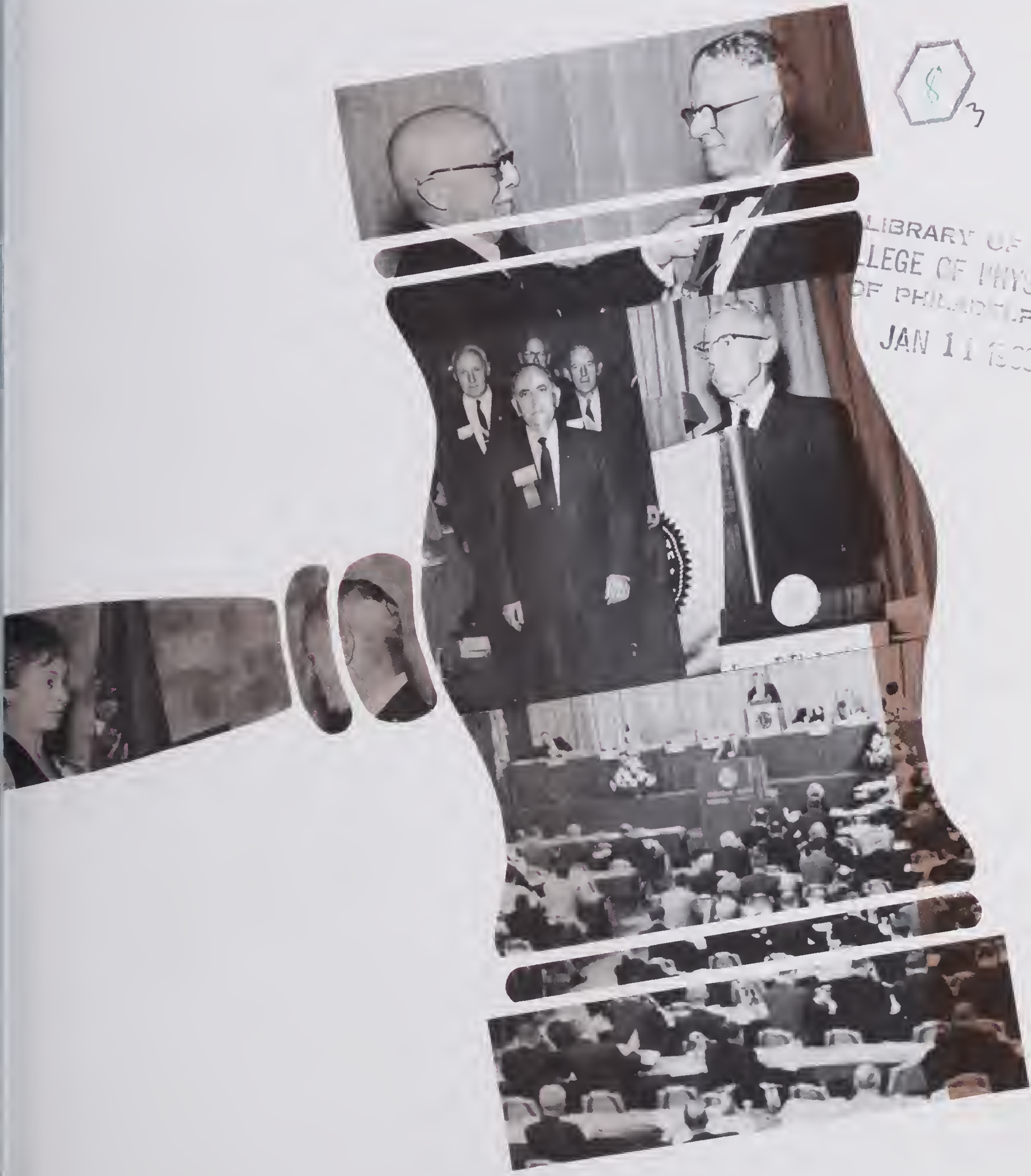

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Digest of Proceedings
1968 MSMS House of Delegates

1968 House of Delegates Proceedings
103rd Annual Session
Michigan State Medical Society

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Michigan State Medical Society
103rd Annual Session
September 22-24, 1968

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The House of Delegates of the Michigan State Medical Society, meeting at the Sheraton-Cadillac Hotel, Detroit, Michigan, on September 22, 23, and 24, 1968, convened at 8:20 p.m. on Sunday, September 22, James B. Blodgett, MD, Speaker, and Vernon V. Bass, MD, Vice-Speaker, presiding.

2. Invocation

The Speaker called upon R. R. Cooper, MD, to give the invocation.

3. Report of Credentials Committee

Chairman K. T. McGunegle, MD, reported, "There are 132 Delegates seated, the majority of whom are not from any one county."

4. Report of Committee on Rules and Order of Business

Chairman H. A. Scovill, MD, recommended adoption of the printed order of business, particularly Item No. 21 thereof which specified that resolutions may *not* be introduced after the close of the second meeting, tomorrow morning, September 23, unless by consent of two-thirds of the seated delegates.

This procedural change, recommended by the House Committee on Procedures and subsequently discussed at Councilor District Conferences, was to expedite the business of the House while still providing full opportunity for the introduction of matters which must be deliberated.

The Committee also recommended that the House give the Speaker the right to recess its proceedings to a time certain at his discretion and without a vote of the body.

Finally, it was recommended that Robert's Rules of Order govern the proceedings of the House, except for recess power.

The report was adopted.

5. Speaker's Remarks — J. B. Blodgett, MD

This is the first annual session of the House at which it is my privilege to preside. The honor of this office is derived from the high character and devotion of those delegates to this House who have represented their colleagues over the years, and from the excellence and fairness of the Speakers who have served this House in the past.

It is the Speaker's duty to conduct the affairs of a deliberative assembly in such a way that the business may be effective, expeditious, systematic, uniform and equitable. The purpose is to implement the rule of the majority and at the same time protect the rights of the minority.

The House and the Speaker are indebted to Dr. Noyes Avery's Committee on Procedures of the House. His recommendations for more efficient conduct of our business have been incorporated into this meeting and are recorded in this report.

One of these innovations is the Tuesday dinner meeting of the House. At that time it will be our privilege to install the new President and to honor our specially distinguished members. I have asked Mr. Stewart Kerr, our Legal Counsel, to act as our parliamentarian. I wish to express my thanks to the staff for their tremendous assistance in preparing for this meeting.

(The following report of the Speaker was presented to the Delegates in printed form.)

This is a brief review of the implementation of resolutions adopted by the 1967 House of Delegates. (For complete text of resolutions with House action, refer to the Digest of Proceedings — Part 2, *Michigan Medicine*, December, 1967.)

Summary.

A. Resolutions adopted:
  1. Commendation or approval: Resolutions 37, 48, 53, 61, 62, 63, 64
  2. Economics: Resolutions 14, 20, 32, 33, 36, 41, 44, 59
  3. Bylaws: Resolutions 7, 8, 39, 55
  4. Legislative: Resolutions 3, 13, 40, 42, 49, 51, 58
  5. Miscellaneous: Resolutions 6, 10, 17, 18, 21, 22, 23, 24, 25, 31, 35, 46, 47, 52, 54, 56, 57, 60

B. Resolutions disapproved: Resolutions 1, 4, 5, 9, 11, 29, 30, 34 (but House appointed Committee to Study Duties of the President), 38, 45

C. No action: Resolutions 2, 12, 15, 16, 19, 26, 27, 28, 43, 50

Res. 1 — Section Delegates, Right to Vote. This resolution was disapproved by the House.

Res. 2 — Hospital Privileges. The House took no action on this resolution.

Res. 3 — Repeal of Basic Science. Although a concerted attempt was made, SB 227 (repeal of Basic Science), which had passed the State Senate in 1967, failed to pass the House of Representatives in 1968, largely because of the refusal of the House State Affairs Committee to permit the House to debate and vote upon the bill. (The 1968 Legislature did adopt a bill, supported by MSMS, which makes possible the waiving of the Basic Science examination for any licensure candidate who has previously passed "substantially equivalent" examinations as given by the National Board of Medical Examiners. This law takes effect 90 days following adjournment of the 1968 session.)

Res. 4 — Definition of Specialist. This resolution was disapproved by the House.

Res. 5 — Rescind Resolution 22, 1966 MSMS House of Delegates. This resolution was disapproved by the House.

Res. 6 — William Beaumont Commemorative Postage Stamp. MSMS prepared a resolution which was adopted by the Michigan Legislature, which will give impetus to MSMS plans, as directed by this resolution, to petition the Postmaster General of the United States to issue a commemorative stamp honoring Doctor Beaumont on the 150th anniversary (1822-1972) of the "Mackinac Island Miracle." MSMS is coordinating its efforts with the State Medical Society of Wisconsin.

Res. 7 — Number of Terms for MSMS Councilors. This change in the Bylaws, limiting to three the consecutive terms Councilors may serve, was incorporated in the 1967 revision of the MSMS Constitution and Bylaws, *Res. 8 — Physical Medicine.* This change in the Bylaws, establishing a Section on Physical Medicine, was incorporated in the 1967 revision of the MSMS Constitution and Bylaws.

Res. 9 — Medical Advisors to Michigan Partners of the Alliance. This resolution was disapproved by the House.

Res. 10 — Board of Pharmacy Rules & Regulations 338.486-16(c). This resolution, requesting that a Board of Pharmacy rule be rescinded, was referred to the MSMS Liaison Committee with the Michigan State Pharmaceutical Association for further study and report back to the House. The Committee is continuing its study of this problem and will make recommendations to the House in 1969. (See Annual Report of Committee.)

Res. 11 — Guidelines on Utilization. This resolution was disapproved by the House.

Res. 12 — Hospital Utilization Review Manual. The House took no action on this resolution.

Res. 13 — Single Medical Practice Act. A proposed bill to establish a single medical practice act is being developed by a subcommittee of the Legal Affairs Committee and will be submitted to the House of Delegates in 1968 for its consideration.

Res. 14 — Joint Committee with State Bar of Michigan to Study the Problem of Malpractice Suits. This resolution, concerning the feasibility of establishing a commission to study the problem of increasing malpractice suits against physicians, has been favorably considered by both the MSMS and State Bar committees. Representatives from both professions soon will be appointed so that this important study can be underway.

Res. 15 — Utilization Control. The House took no action on this resolution.

Res. 16 — Utilization Control. The House took no action on this resolution.

Res. 17 — Financial Remuneration for MSMS Officers. This resolution directed the Finance Committee of The Council to investigate the concept of adequate financial remuneration for MSMS officers, and suitable means of securing funds for this purpose, and report to the 1968 House of Delegates.

The Finance Committee has studied this matter during the past year and surveyed past officers of MSMS. The Committee finally concluded that there was no general agreement on the question of remuneration as to method, amount, desirability, or who should be remunerated. (See Annual Report of The Council for further detail.)

Res. 18 — Health Information Research Institute. This resolution directed The Council to provide for organizational expenses of the Health Information Research Institute incidental to its incorporation, materials necessary to present the principles of the Institute to prospective sponsors, and such seed money as The Council deems necessary and available within the limits of its present budget.

This item was considered by the Finance Committee and The Council and incorporated in the 1968 MSMS budget.

Res. 19 — Hospital Utilization Review Manual. The House took no action on this resolution.

Res. 20 — Physician Responsibility for Physical and Occupational Therapies. This resolution, which related to procedures of the carrier and fiscal agent for the Medicare program, was forwarded to Michigan Medical Service for study and implementation.

Res. 21 — Chiropractic. This resolution "encouraged MSMS to initiate an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult." Educational conferences on health quackery were held in Detroit and Lansing for the public and physicians. Recommendations for a new ongoing "MSMS Committee on Health Quackery" to carry out an educational effort grew out of the Lansing invitational conference April 1 and were adopted by The Council in June. This committee now will seek continually to educate the public about quackery, including the cult of chiropractic.

Res. 22 — Study of Adequacy of Training of Certain Para-Medical Personnel. This resolution directed the Committee on Rehabilitation, with the Education Liaison Committee, to study the adequacy of training, the practice procedures allowed, and the limitations of responsibilities of physical therapy assistants, and report to The Council. Preliminary discussions were held with the three medical schools on this question. However, the Committee on Rehabilitation did not feel it could make the study as outlined in the resolution, but felt that it was in a good position to review such programs which come into existence in the state. The Committee has been aware of such programs in Michigan, through some of its committee members, and felt that the existing programs had adequate curricula. The Committee will review any new programs for teaching and training paramedical personnel in the state and will keep The Council informed.

Res. 23 — Recognition of the Board of Registration of Physical Therapists. This resolution instructed the MSMS Rehabilitation Committee to inform MSMS members re "qualifications of the different groups of practicing physical therapists." After considering this resolution, the Rehabilitation Committee informed The Council that "there is only one body of registered physical therapists, with no other level of physical therapists being recognized at this time. The Michigan law definitely sets forth the qualifications of a physical therapist. An explanatory letter and a copy of the Michigan law was sent to component society secretaries."

Res. 24 — AMA Delegation Chairman to Attend Council Meetings. This resolution directed that the current AMA Delegation Chairman be invited to attend all meetings of The Council and this is routinely done.

Res. 25 — Care of Handicapped Children. The House took no action on this resolution re MSMS support of the Michigan Ad Hoc Committee for the Care of the Handicapped Child, but did approve its intent. The reference committee noted "that this effort is in accord with the reference committee's recommendation that a new special committee of MSMS be formed for coordinating the care of the handicapped children." The reference committee recommended, therefore, that the Ad Hoc Committee of the American Academy of Orthopedic Surgeons channel its efforts through the MSMS.

After considering this resolution and the referenece committee action, the MSMS Committee on Rehabilitation adopted a motion that the Committee cooperate in all ways possible with the Committee for the Care of the Handicapped Child of the American Academy of Orthopedic Surgeons and maintain liaison with the other organizations, agencies and departments involved in the care of handicapped children.

Res. 26 and Res. 27 were withdrawn by the introducers.

Res. 28 — Physician Involvement in Operation of Variable Fee Program. The House took no action on this resolution.

Res. 29 — Blue Shield Responsibility to House of Delegates. This resolution was disapproved by the House.

Res. 30 — Michigan Medical Service. This resolution was disapproved by the House.

Res. 31 — Supporting Appropriations for Four-Year Medical School at MSU. This resolution directed MSMS to support the request of the State Board of Education for an appropriation to enable MSU to expand its College of Human Medicine to a four-year medical school.

Letters indicating MSMS support of this request were sent to the Governor and other appropriate state officials, and subsequently the requested funds were appropriated by the Legislature.

Res. 32 — Participation in Michigan Medical Service. This resolution recommended to the Board of Michigan Medical Service that individual case participation be allowed in all new contracts.

The resolution was transmitted by letter to Michigan Medical Service for information and implementation. Subsequently MSMS reported to The Council that a study was being undertaken to determine the effect of per case participation on the overall participation program.

Res. 33 — Blue Shield "Action Line" for Medicare-Medicaid Cases. This resolution recommended to the Michigan Medical Service Board that it "establish a better mechanism than is now present to resolve promptly questions from doctors concerning Medicare and Medicaid cases."

This resolution was transmitted to MMS by letter for information and implementation. Subsequently Blue Shield reported to The Council that in the fall of 1967 a special handling section was established for processing status inquiries. The staff of the Personal Services Department was increased, and the number of Professional Relations and Telephone Service representatives was increased. A new modern Telephone Service area has been constructed in the headquarters office to speed internal handling of physicians' calls. In addition, a member of the Blue Shield public relations staff is coordinating the handling of especially urgent or sensitive inquiries and expediting their processing in cooperation with other Blue Shield departments.

Res. 34 — Responsibilities of MSMS President. This resolution was disapproved by the House. However, the House approved a reference committee recommendation that an ad hoc committee of the House of Delegates be appointed to re-evaluate the executive duties of the President. This committee is studying the matter and will report directly to the House.

Res. 35 — Approval of Screening Programs. The resolution directed that The Council limit its approval of screening programs to those previously approved by the component medical society or societies in which the program is to be carried out.

This MSMS policy was in effect prior to the time the resolution was adopted, so no further action was required.

Res. 36 — Proposed Blue Shield Benefits for Sterilization. The resolution directed that MSMS through appropriate officers apprise Michigan Medical Service of the Society's opposition to the MMS restriction denying surgical benefits for sterilization procedures, and request that the restriction be eliminated.

This matter was brought to the attention of the Blue Shield Board by MMS officers and Blue Shield has advised MSMS that the Blue Shield Medical Advisory Committee has approved the inclusion of inpatient male and female sterilization for medical necessity as a benefit under the M-75 program. It already is included in the new MVF programs.

Res. 37 — Honoring Physicians Who Have Served in Viet Nam. This resolution commended several Michigan physicians who had served in Viet Nam.

The March issue of *Michigan Medicine* was dedicated to MSMS members who have served in Viet Nam during the past year, with articles and photographs by and about the physicians. (AMA plaques honoring physicians who have served in Viet Nam since the 1967 House of Delegates will be presented at the 1968 House of Delegates meeting.)

Res. 38 — New Blue Shield Program, Deletion of Certain Benefits. This resolution was disapproved by the House.

Res. 39 — Medical Society Membership for Osteopathic Physicians. This resolution directed that component medical societies be encouraged to offer associate memberships to osteopaths on an individual basis, and outlined provisions whereby such associate members of component societies could be admitted to associate membership in MSMS.

Component society officers were informed of the resolution and its contents by letter, and appropriate publicity appeared in *Michigan Medicine.*

Res. 40 — Revision of Michigan's Abortion Laws. This resolution directed that MSMS work toward the revision and liberalization of the Michigan abortion laws. The House adopted a recommendation of the reference committee that an MSMS ad hoc committee formulate a position statement on therapeutic abortion and report its findings to the House at the 1968 session.

The special committee has been appointed and will make its report to the House.

Res. 41 — Inclusion of MDPAC in MSMS Dues Billing. As directed by the resolution, the MDPAC donation was included in the MSMS dues billing with a note that this portion is voluntary and not deductible.

Res. 42 and Res. 49 — Separate Michigan Department of Health Covering Health-Related Activities. These resolutions directed that MSMS contact the Governor informing him in the most forceful way possible that MSMS supports the retention of health-related activities within a strong separate Michigan Department of Public Health.

Immediately following the House of Delegates meeting, a letter was sent to the Governor, presenting in some detail and in a forceful manner the MSMS views on this subject. The Governor felt that a merger of the State Department of Public Health and of the State Department of Social Services at present would be inappropriate.

Res. 43 — Support of AMA Policies on Health Services. The House took no action on this resolution.

Res. 44 — Joint Billings of MDPAC Contribution with MSMS Dues Statement. (See implementation of Resolution 41 above.)

Res. 45 — Contracts for Physicians' Services. This resolution was disapproved by the House.

Res. 46 — Medical Student Preceptorship Program. This resolution directed that MSMS, in cooperation with the three Michigan medical schools and their SAMA chapters, establish a preceptorship program throughout the state.

The Council referred this resolution to the Education Liaison Committee. The possibilities of establishing a preceptorship program as requested by the resolution are under study by the Committee and representatives of the three medical schools. In effect, this is a continuing study (which has many ramifications) of a preliminary investigation several years ago by the same Committee.

Res. 47 — Local Responsibility for Health Programs. The resolution specified two kinds of action: 1) That MSMS charge component medical societies with the responsibilities of establishing effective lines of communication with the local health departments and local chapters of all voluntary health organizations and agencies, and 2) that MSMS urge component medical societies to periodically inform the agencies and organizations that the component medical societies recognize their responsibility in all health programs, screening programs, etc.

A letter developing the intent of this resolution was sent to every component medical society; and related letters were sent during the year dealing with such specific matters as component society involvement in disaster emergency medical care planning, health manpower and recruitment, etc.

Res. 48 — Wayne State University Centennial. The resolution directed MSMS to present an award to WSU honoring the WSU Centennial and to call the centennial to the attention of the AMA House of Delegates. The AMA concurred in an MSMS-sponsored resolution at the winter AMA House of Delegates meeting, recognizing the WSU Centennial. A framed copy of the 1967 MSMS House of Delegates resolution was presented to WSU during its centennial observance in the spring.

Res. 49 — Separate State Health Department. (See implementation under Res. 42 above.)

Res. 50 was withdrawn by the introducer.

Res. 51 — Driver Capability and Re-Evaluation for Licensure. This resolution directed MSMS to "offer its services to the Legislature and the Secretary of State in an advisory capacity to assist in the development of means whereby a fair evaluation of driver capabilities may be accomplished permitting the restriction or withdrawal of driving privileges from those judged to be physically or mentally incapable."

Attempts by the Highway Injuries Committee and the Legal Affairs Committee to secure legislation were unsuccessful. However, the matter is still under consideration by the Secretary of State's office for 1969.

Res. 52 — Physician Representation on Hospital Governing Boards. This resolution stated that hospital boards of trustees should have adequate medical representatives. The intent of this resolution was transmitted by letter to the Michigan Hospital Association. In response MHA indicated that it agreed that improved communications were necessary, and that it favored the joint conference committee approach, whereby chairmen of the different medical services and the chief of staff meet with an equal number of representatives of the Board of Trustees and the hospital administrator.

Res. 53 — MSMS Support of 1968 Student American Medical Association Meeting in Detroit. The resolution directed that The Council and staff extend all possible cooperation and support to this SAMA convention.

After consultation with SAMA officials, The Council authorized a $500 program grant and staff assistance to SAMA for this national meeting.

Res. 54 — MSMS Liaison with Students of the Health Care Professions. This resolution directed appointment of a liaison committee with students of the health care professions in order to extend the availability of medical care.

The Council requested the Liaison Committee with Residents, Interns and Medical Students to implement the intent of this resolution. The Committee is now studying possibilities for extending liaison with students of the health care professions, in order to appropriately implement the resolution.

Res. 55 — Antidiscrimination in the Michigan State Medical Society. This resolution proposed an amendment to the MSMS Bylaws adding a sentence, "There shall be no discrimination on the basis of race, religion, sex, or ethnic origin."

This change was incorporated in the 1967 revision of the MSMS Constitution and Bylaws.

Res. 56 — Development of Physicians' Hospital Privilege Act. The House instructed the Legal Affairs Committee to study the feasibility of developing a Physicians' Hospital Privilege Act embodying the intent of the AMA resolution that all doctors of medicine be accorded hospital privileges commensurate with their training, experience and competence.

A Legal Affairs Committee special study group has concluded that such a law would not be feasible. It is recommended, however, that the House of Delegates again reaffirm its position that no ethical physician should be refused staff privileges for reasons of race, creed or color.

Res. 57 — Creation of an MSMS-Sponsored Academy of Medical History as a Division of the Historical Society of Michigan. Alfred H. Whittaker, MD, a member of the MSMS Committee on Michigan Medical History and introducer of the resolution, is working with the Michigan Historical Society to establish a medical history branch within that Society.

Res. 58 — Clarifying Michigan Law to Safeguard Privileged Character of Medical Records. This resolution directed that MSMS work with the State Bar and the Legislature to clarify and strengthen Michigan laws and court rules re safeguarding the privileged character of medical records.

A subcommittee of the MSMS Liaison Committee with the State Bar of Michigan has been appointed and will meet soon with a State Bar subcommittee to study this matter.

Res. 59 — Appeal Mechanism for Unresolved Adjudication. This resolution directed MSMS to establish an appropriate appeal mechanism available to MMS or the physician concerned in cases of unresolved adjudication.

The Council adopted an opinion of the County Societies Committee that adequate appeal mechanisms already exist and that our knowledge of the existing machinery should be routinely made available to carriers other than Blue Cross-Blue Shield. In The Council's view no further action need be taken.

Res. 60 — Acceptance of Osteopaths as Residents and Interns. This resolution directed that the AMA Council on Medical Education be requested to amend its position so that osteopathic graduates might be accepted as residents and interns.

This resolution was brought to the attention of the AMA Council on Medical Education by letter shortly after the House of Delegates meeting and subsequently a Michigan resolution to this effect was introduced into the AMA House of Delegates at its June, 1968, meeting. The AMA resolution was referred to the Board of Trustees and the Council on Medical Education for consideration.

Res. 61 — Health Council's Silver Anniversary. The House of Delegates commended the Michigan Health Council (and the various foundations which contribute financial support) for its "past accomplishments and present programs." The Council presented a citation (officially explaining the action by the delegates) to the Health Council during the midsummer meeting at Mackinac Island, when Health Council officials met with The Council for presentation of their annual report.

Res. 62 — Commendation of Retiring Director of Michigan Department of Public Health. The House suspended the rules and adopted this resolution by a rising vote. The resolution recognized "the distinguished and outstanding service" of Doctor A. E. Heustis, retiring director of the Health Department. An illuminated copy of the resolution was presented to Doctor Heustis upon its adoption.

Res. 63 — Appreciation to Speaker Lightbody. The resolution called for appropriate recognition of the fine service by Doctor Lightbody as retiring Speaker of the House of Delegates. A framed pen-and-ink sketch of Doctor Lightbody with a small printed note of appreciation under the sketch was presented to Doctor Lightbody at the Midsummer Session of The Council.

Res. 64 — Commendation to Vice-Speaker Hayes. The resolution asked that a suitable commendation be presented to Doctor Hayes as retiring Vice-Speaker of the House. A framed copy of the resolution was presented to Doctor Hayes at the MSMS Conference on Health Care Planning in Detroit in February.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the Report and commended the Speaker for the printed Summary.

6. Remarks of AMA President-Elect G. D. Dorman, MD

Doctor Dorman addressed the House on the subject of "Unity in Medicine."

7. President's Address — Bradley M. Harris, MD (extracted)

The federal establishment has an ever increasing role in medical care. We must continue to be alert and interested and provide leadership in the programs which concern federal medical legislation. Within the next two months we will elect a new House of Representatives and a new president. I realize that I am repetitious but I cannot urge you too strongly to become actively involved both financially and physically in both the national and state political campaigns. The 90th Congress is examining Medicare in terms of cost and need and there will be changes in regard to administration of the programs. We have a vested interest as physicians, as well as taxpayers, in this legislation. It behooves each of us to make our views apparent to the candidates. The Heart Cancer and Stroke program has expended something over a million dollars in Michigan to date without visibly influencing the care of any significant portion of the population. This is intended to provide, among other projects, a continuing educational program directed to the practicing physician. Our Society has conducted in collaboration with our medical schools a very successful program for many years. The opportunity to expand and intensify these efforts would appear to be the most immediate and feasible method at this time.

I would urge a closer liaison between the director of the program and our Postgraduate Committee to the end of early development of this available source of dissemination.

Medicine is a proud profession and I am certain it will always be. But we are not too proud to ask the help of intelligent and dedicated laymen when their assistance can aid us in increasing the quantity and quality of medical care we can offer our patients.

For some time the Michigan State Medical Society has been on record as favoring the expansion of the medical schools at the University of Michigan and at Wayne State University. Further, we have strongly endorsed the expansion of the two year medical school at Michigan State University to a four year school. Concomitant financial support through action of the Michigan Legislature is necessary.

Although there is a strong basic science program at Michigan State, and the new life sciences building and additional faculty will expand these facilities, the present great need is financial support to develop the clinical areas of the medical school curriculum to qualify as a Class A four year medical school.

I suggest that we should strongly urge the development of citizens groups to augment our appeal to the legislature to provide the support necessary to bring this program to fruition. This must be accomplished prior to any commitment to a fourth tax-supported medical school in Michigan.

At the request of the 1967 House of Delegates an Ad Hoc Committee has produced a single medical practice act which will be introduced into the next session of the Michigan Legislature. They have accomplished a monumental task. I think we must realistically recognize that this will meet with opposition. The other disciplines will most certainly resist for various political reasons, with which you are familiar.

Here again the wide spread support of citizens groups in support of a single standard in the healing arts can be of inestimable assistance.

The Ad Hoc Committee requested in Resolution 40 of the 1967 House has studied the Therapeutic Abortion Problem in depth. Their report which is before you, I feel presents an affirmative position which the Society can support without apology.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recognized the fine work of the President during the year, noted his recommendations and "particularly urged each county society to develop citizens' groups to augment our appeal to the Legislature to provide necessary support for our program" seeking expansion of MSU to a four-year medical school.

THE HOUSE adopted the report of the Reference Committee.

8. President-Elect's Address — James J. Lightbody, MD (extracted)

This is the first opportunity I have had to express to this House of Delegates my deep appreciation for the privilege of being your Speaker of the House for the past eight years and as Vice-Speaker for three years before that. During those eleven years as an officer of this House of Delegates, I was extremely fortunate to have had the opportunity of working with some very fine and capable men. During my three years as Vice-Speaker, Doctor Ken Johnson was the Speaker of the House, and he taught me a great deal about motions, amendments, and amendments to the amendments — and also how to handle people who were partly or completely out of order. Ken Johnson and I had an exciting three years together.

During my eight years as Speaker of this House, I was also very fortunate to have the services of three capable colleagues as the Vice-Speaker — John Rice of Jackson — Harold Falls of Ann Arbor — and Lou Hayes of Gaylord.

I want to thank these men at this time for their able assistance and I am sure we are all very sorry that because of added professional responsibilities, they chose not to continue on as Speakers. This brings us up to the present, and the administrative affairs of this House are now in the very capable hands of Jim Blodgett, of Detroit, and Vern Bass of Bay City — I wish them continued success.

The Michigan State Medical Society is now 103 years old, and there are times when I feel that I have been a member all of those years — then there are many other times when I feel excited, rejuvenated, and highly enthusiastic about our present and future plans and programs.

There is, at present, an acute imbalance between demand and supply of physicians to serve the ever-increasing population of our urban areas. Medical schools are attempting to face this problem by increasing the number of admissions to medical schools and also by making certain changes in their curricula. We also know that an increase in the supply of physicians alone will not solve the dilemma. We see an imbalance in our physicians' pool because of the increase in the number of young physicians who are choosing research for their major interest, so this obviously affects the supply available for patient care. Another reason for the shortage is that about 10% of licensed physicians in this country are now working in the armed services or in administrative positions.

The answers may come by developing greater utilization of the allied health scientists and other paramedical personnel — and with the increased popularity of so-called "group practice" to decrease the strain on individual practitioners.

There is going to be more and more impersonalization of patient care, and this means that the traditional face to face confrontation of patients with physicians may be on a limited basis in the future.

One of the matters of great current interest to the Michigan State Medical Society is its relationship with the Negro physicians in this state, and this, I believe, is a major challenge and should be squarely met with the indorsement of a coordinated, bilateral program to improve our communications with the Detroit Medical Society and the National Medical Association. Negroes constitute 11.4% of the nation's population, but have only 2.2% of the nation's physicians. According to a recent report released by the American Association of American Colleges, approximately 300 Negro students are expected to enter United States medical schools this fall. This represents a 50% increase over the situation five years ago.

The majority of Negro physicians have felt that the American Medical Association did not have a realistic motivated program to assure better care for Negro patients and did not fully comprehend the professional load that the Negro physicians of this country were carrying in attempting to take care of the great number of Negro patients. The difficulties that some Negro physicians have had in gaining hospital staff appointments is well-documented, but this is also true of some white physicians.

Negroes have served in the Volunteer Physicians for Vietnam Program — They have served in the Armed Forces Medical Corps — and have served aboard the steamship Hope and have actively participated in many local and national health programs. Michigan was recently honored by having Doctor Lionel Swan as President of the National Medical Association, and Doctor Swan is a member of our State Medical Society.

Another milestone in this area of interest, was the action of the American Medical Association House of Delegates in amending their Bylaws so that constituent societies might have their charter revoked if found guilty of racial discrimination.

The importance of the entire problem was highlighted at the recent annual meeting of the National Medical Association where President Lyndon Johnson put in a surprise appearance and spoke to their House of Delegates.

Specifically, I would suggest that state and county medical societies re-evaluate their interests in programs affecting the medical care of both the black and white poorer segments of our urban areas particularly, and make every effort to improve the professional relations of Negro physicians in all areas of health activities.

I feel, however, that Negro physicians themselves should make a greater effort to participate in county and state medical societies' programs and activities so that we can eventually eliminate any racial inequities that may now exist.

The education of the physician is an endless process — and we should continue to encourage medical education at all levels beginning in the medical schools and continuing through all postgraduate levels into specialty societies and hospital education programs. We now have three medical schools in this state and their postgraduate programs are of the highest caliber.

We should also continue to support the activities of the state and local health departments as their activities many times overlap with our own health programs concerned with direct patient care. Another matter of major concern is the care of the older people who are chronically ill. We must see the older patient as one of the great challenges in medicine rather than a candidate for custodial care. First class care for older people will lead to improved, preventive measures for younger ones. This frequently involves participation of county, state and federal programs, but this is going to be an expanding area of activity in the years ahead and the medical profession must concern itself in cooperating with and giving direction to public agencies.

The scientific progress of medicine — its skyrocketing per diem costs in hospitals — and the mounting shortages of personnel to deliver high quality medical care are causing far-reaching changes in the traditional doctor-patient personal relationship throughout the whole spectrum of health service. The benefits of latest medical techniques can be delivered only through the inter-action of many specialists, and that in itself inevitably introduces an element of impersonality in the way the patient is treated.

It is fashionable in some quarters to level a constant barrage of criticism at physicians. Doctors are blamed for all the ills of society from juvenile delinquency to air pollution. This is both unjust, unfair and not based on the facts. The so-called "image" of the physician is still considered to be the highest and best of the professional and nonprofessional groups. American physicians should be congratulated on their outstanding cooperation with the "Medicare" program. The medical profession, with rare exceptions, has accepted the verdict and has worked hard to make the Medicare program an outstanding success.

The new direction in which American medicine is going is not necessarily bad because it is different. William Osler wisely said: "The philosophies of one age become the absurdities of the next, and the foolishness of yesterday has become the wisdom of tomorrow."

Let us hope that in the year ahead, that we, as physicians, will continue to give the best medical care possible to all segments of our population. The changes we are seeing in medical practice and hospitals are medical expressions of the same changes that will occur in education, industry, government and in the entire social landscape.

The transition of our medical care system simply mirrors the transition of our whole society. Let us hope that this transition will bring some degree of stability — and perhaps, some degree of tranquility.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, noted that Dr. Lightbody had many constructive programs planned for next year and approved of his suggested courses of action.

THE HOUSE adopted the report of the Reference Committee.

9. Address of Woman's Auxiliary President — Mrs. W. G. Gamble, Jr., (extracted)

Our component auxiliaries are small and large, social as well as service organizations, but all have a common denominator — members have demonstrated their concern for people and their communities by participation in various medically oriented projects.

Priorities stressed this year were: Legislation, Health Careers, AMA-ERF, and a new committee, Home Centered Health Care. With an overall concern for membership, there was an increase of 85, bringing the total to 3,566 members. By supporting various fund-raising activities, the counties have continued their support of the American Medical Association Education and Research Foundation with a total contribution of $20,964.82. Macomb County received an achievement award at the National Convention — the third such award this County has received.

One of the first states to appoint a Home Centered Health Care Chairman, we are proud to report our own county, Bay-Arenac-Iosco, initiated a Mobile Meals program on April 1.

Over $18,000 for scholarships and loans for paramedical careers — over 50 Health Career Clubs in the State — 11 Health Career Days sponsored by auxiliaries indicate the response to the challenge in Health Careers. The Careers Mobile toured again in some counties with members assisting as guides or in whatever capacity requested.

International Health Activities again proved to be a popular project, with approximately 30,000 pounds of pharmaceuticals and equipment collected for various outlets, with World Medical Relief the main beneficiary.

With the assistance of MSMS, the Auxiliary held its first Legislative Day in March. In addition to State officers and chairmen, all county presidents, presidents-elect and legislation chairmen were invited to the day-long program which began at MSMS headquarters under the direction of Mr. Riley. Then, a trip to the Capitol where appointments had been arranged for each Auxiliary member to meet with either her representative or senator. This informative program was exceptionally well received, and attending members feel better prepared to assist physician husbands in influencing good legislation in the Health field.

Community Health's large umbrella has covered a wide range of programs: The film, "Parent to Child About Sex," has been extensively shown; assistance with immunization clinics, Headstart programs, and distribution of Health Education materials, *Today's Health* and *Health Guide*. Interesting safety programs have been on "Flammable Material," "Air Pollution" and "Self Defense."

We look back over the year with pride in the many accomplishments of our county Auxiliary members. Necessarily, we must add, wistfully, our wish for more active members.

Communications always seem to be a roadblock. Do you know what the Auxiliary is doing in your community? Have you invited your county auxiliary president to report at an executive committee meeting of the county medical society? Are you personally in favor of your wife actively working in the Auxiliary? We hope the above will be answered in the affirmative.

The Auxiliary is an organization whose goals and objectives have been clearly defined. Our main purpose is to assist the MSMS in its program for the advancement of medicine and health education. We can only fulfill our objectives with your total support.

We have kept our membership informed with our State newsletter, *The Auxilium,* issued quarterly. In addition, the pages of *Michigan Medicine* contained five articles about Auxiliary participation in activities we thought would be most interesting to physicians.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, noted the many accomplishments of the Auxiliary and commended it for its activities during 1968.

THE HOUSE adopted the report of the Reference Committee.

10. Remarks of Michigan State Medical Assistants Society President — Mrs. Nelda Gasperson (extracted)

The Michigan State Medical Assistants Society is again well represented on the national level this year. Mrs. Betty Lou Willey was elected Speaker of the House and is candidate for this office this year. Several MSMAS members serve on AAMA committees. These include Mrs. Dorothy Brandis, member of the Resolutions Committee, and Miss Donna Hislop, CMA, a member of the Certifying Board. Miss Phyllis Marquardt, CMA, and Doctor Millard assisted in an approval program of the Medical Assistants Course at the Traverse City Junior College on behalf of the AAMA.

In November, 1967, the County Officers and Committee Chairman Conference was held in Lansing with a total registration of 121 members.

Miss Phyllis Marquardt, CMA, Public Relations Committee Chairman, represented MSMAS at the Silver Anniversary meeting of the Michigan Health Council. The Eleventh Annual Educational Seminar was held in Flint with an attendance of 150. Mayor Floyd J. McCree of Flint welcomed the group and proclaimed April 21 as "Medical Assistants Day."

Our Summer Seminar was held at Boyne Highland Lodge with 180 registered — the largest attendance ever for a Summer Seminar. This meeting was hosted by the Washtenaw County Medical Assistants Society.

Membership in MSMAS as of June 30, 1968, is 752, an increase of 13 since June 30, 1967. Gratiot County will be presented with its organizational charter this year and if Barry County has had its Constitution and Bylaws approved it too will receive its charter.

Our Bulletin, published quarterly, was awarded first place in the AAMA annual award contest in 1967.

A grant of $500 from The Council of MSMS to our Education Committee was gratefully acknowledged. This grant will aid the committee in establishing a survey of community colleges and subsequent standardization of medical assistants training programs offered by the colleges.

Many thanks are directed to MSMS for the use of the headquarters for our Board of Directors meetings and to our advisors G. E. Millard, MD, F. C. Cretsinger, MD, W. T. Davison, MD, and B. H. Alford, MD, for their direction and advice.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, praised the activities of the Medical Assistants and recommended approval of the President's Remarks.

THE HOUSE adopted the report of the Reference Committee.

11. Progress Report on the MSMS Judicial Commission — D. N. Sweeny, Jr., MD, Chairman

The Commission has met quarterly and on call for emergency matters. I would like to discuss only six of the problems which we have dealt with in the past 12 months.

1. *Election of Councilors.* The Commission spent much effort on problems concerning eligibility for membership on The Council of the Michigan State Medical Society. This problem stemmed from a complaint received by the Commission shortly after the last session of this House when previously established rules were changed. The action and recommendations in this regard of the local county society were reviewed and accepted by the Judicial Commission.

The Commission has concluded that the chief cause of this misunderstanding and other misunderstandings involved in such matters stems from the cumbersome mechanism by which Councilors are elected. We have suggested therefore, Mr. Speaker, that it would be advisable to amend pertinent sections of the Constitution and Bylaws of the Michigan State Medical Society anent the election of Councilors. It would seem more appropriate that Councilors be nominated and elected by the physicians of Councilor districts whom they represent, rather than by the House of Delegates as a whole. Your Judicial Commission clearly recognizes that it has no authority over the operation of the House of Delegates. We do feel, however, a deep obligation to the Society in the prevention of future complaints and serious misunderstandings of this type.

2. *Handling of Complaints by Component County Medical Societies.* The Commission is pleased to report that county societies are doing an excellent job in their handling of the complaints that are forwarded to them from the Commission. As you know, it is the policy of the Commission to have all complaints resolved at the local level whenever possible. A subcommittee of the Commission is now preparing guidelines to be used by county societies in the investigation and determination of complaints. These guidelines will be completed and sent to all county societies.

3. *Closer Liaison with the State Board of Registration in Medicine.* Your Commission has an active subcommittee working on the problem of the physically or mentally incompetent physician. We have had dialog with the State Board of Registration in Medicine in an attempt to develop safeguards so that both the public and the profession will be better protected from anyone being allowed to practice medicine in this State who is not qualified physically, mentally or professionally.

4. *Physician-Hospital Relationships.* Your Judicial Commission is deeply disturbed by the increasing number of squabbles that mar the otherwise harmonious relations between hospital administrations and the medical staffs. The Commission was helpful in resolving a serious problem that had developed in Detroit in this context. We understand a resolution dealing with this subject has been introduced at this session of the House of Delegates, and we urge its most serious consideration by the delegates.

5. *Relationships Between Doctors of Medicine and Doctors of Osteopathy.* The Judicial Commission rendered an additional opinion to a local county society that it is ethical for a doctor of medicine to associate in practice with a doctor of osteopathy providing the osteopath in question practices scientific medicine. As you know, this opinion is consonant with the opinions of the AMA Judicial Council and the MSMS policy concerning doctors of osteopathy that was established by the MSMS House of Delegates in 1964.

Our opinion, however, contained an important proviso that all information reaching the public regarding such an associate must clearly indicate that he is a doctor of osteopathy and not a doctor of medicine.

6. *The Ethic of Incorporation by Physicians Under the Michigan Professional Corporation Statute.* Upon request of a county medical society, the Commission has proclaimed that professional corporations are ethical, since

such associations are covered under an earlier determination of the AMA Judicial Council, and that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, and other lawful groups, providing that the ownership and management of the affairs thereof remain in the hands of licensed physicians.

I will not detail any of the further complaints that have come before your Judicial Commission.

Mr. Speaker, the Commission's work would not be possible without the help of our staff coordinator, Mr. Richard Campau. Because of the implications of due process and abrogation of the right to earn a living in many of the complaints received by the Judicial Commission, we could not function nor do we intend to try to function without the personal guidance of our Legal Counsel, Mr. Stewart Kerr. I am privileged by my position as Chairman of the Judicial Commission to publicly thank these gentlemen for their help.

I speak, Mr. Speaker, for your Judicial Commission, composed of the following doctors: Harold Furlong, Vice Chairman; Sherman Andrews; Louis Bailey; Norbert Scholle; Robert Hamburg; Willis Huron; Robert Powers; R. W. Teed, and Hugh Fuller.

THE SPEAKER stated that this was a progress report of the Commission for information and would not be referred to a reference committee.

12. Report of Michigan Delegation to the American Medical Association — Luther R. Leader, MD, Chairman

Doctor Leader summarized a 15-page printed report on the June meeting of the AMA which had been distributed to the Delegates in advance.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, complimented the Delegates on their work and received the report for information.

THE HOUSE adopted the report of the Reference Committee.

13. Remarks of Michigan Medical Service Board Chairman — John M. Wellman, MD

The report of Michigan Medical Service consists of three items:

1. The Michigan Medical Service Report of 1967, which is contained in your Handbook under the title "Program for Progress," was mailed to each physician in the State of Michigan in the spring of 1968. This covers in detail our activities for the year 1967.

2. Included in your Handbook is our Annual Report to The Council and the House of Delegates as of this date. In essence this consists of a resume of the reports which we have made periodically to The Council since the last meeting of the House. It also summarizes our operational activities for the first six months of 1968. It includes actions taken on resolutions adopted by the House of Delegates in 1967 which were referred to Michigan Medical Service, and finally some comments about the future role which prepayment plans will play in the field of medical economics. (Reprinted below)

3. In support of this report for the first six months of 1968, you have received today a pass-out reiterating the basis for payment under the Michigan Variable Fee Program and an explanation of the determination of reasonable charges.

We appreciate the opportunity to present these reports for your consideration.

14. Annual Report of Michigan Medical Service — John M. Wellman, MD, Chairman; John C. McCabe, President

The work of Michigan Blue Shield in 1967 was outlined in our report to The Council and House of Delegates in September, 1967. Details were published this spring in the Annual Report, entitled "Programmed for Progress."

The latter report reflected Blue Shield's continuing growth and highlighted the finalization and preparation for implementation of the Variable Fee Program.

The year 1967 was one of progressive change as well as of productive Blue Shield activity. It was characterized not only by significant enrollment increases in regular programs and the number of Michigan citizens served under government programs, but also by an increase in claims submissions due primarily to Medicaid, which nearly doubled its total volume of 1966.

This present report is intended to inform The Council and the House of Delegates concerning Blue Shield activity from January 1, 1968, through June 20, 1968.

The MVF Program

The most significant and concerted effort of the first half of '68 concerned the finalization of our planning and implementation with respect to the new Michigan Variable Fee (MVF) Program.

In addition to many operational activities, both internal and external, this implemental process involved consideration of the reaction and the degree of satisfaction of the publics served by Blue Shield, both professional and consumer. On the professional side it meant describing and explaining the new payment mechanism which involved not only higher payment levels but understanding and acceptance on the public's part.

The slow rate of participation especially among M.D.'s continues to be of concern. While the overall percentage of physicians in the State who participate with Blue Shield rose from 56.4% in January '68 to 65.7% as of June '68, the rate of growth on the part of the medical profession has lagged behind other participating professions. As an example, M.D. participation went from 60.6% to 61% for this period, while participation by Osteopaths went from 44% to 67%.

There is satisfaction, however, and significance also, in the fact that the first six months of '68 has seen a marked reduction in the number of resignations by participating physicians. For instance, only two physicians resigned during the month of June.

Enrollment

The groundwork for the MVF enrollment effort was laid in the summer and fall of 1967.

At the end of June, 1968, and prior to formal presentation of the MVF Program to the general public, 20,265 MVF contracts were put into effect, representing 286,260 members. This number did not include major accounts scheduled for conversion to MVF following the June 30 date.

Despite the increased costs which occur in some cases currently and the prospects of higher costs in the future, public acceptance of the program has been most gratifying.

Including individuals with Complementary coverage, over 3,500,000 people or 80 percent of Michigan Blue Shield's membership will be under the MVF programs by the end of 1968.

Charge Patterns

The Blue Shield benefit program for Steel Groups in August, 1967, was the first Michigan program to employ the "customary and prevailing" concept of fees for providers.

Between August, 1967, and April, 1968, there were several adjustments in screen levels under the Steel, Uniroyal, and other reasonable, customary, and prevailing fee type programs, including government programs administered by Blue Shield. These adjustments were applied to the prevailing screen data developed for upcoming MVF procedures during the first half of 1968.

The use of MRVS as a measuring and screening device for reasonable charge determination is slowly being reduced as charge patterns develop with more clarity under all programs administered by Blue Shield.

The Physician's Manual

Because of the complexity of the changeover from M-75 to the new MVF Program and the new systems and procedures which the latter required, a complete revision of the Physician's Manual was undertaken early in 1968.

The new manuals were distributed to all physicians in June, 1968. They incorporated materials and information designed to ease program transition.

The manuals include new procedure codes for MVF, plus a greatly simplified Doctor's Service Report form, together with appropriate instructions and illustrations relative to their use.

The new systems and procedures are aimed at achieving a complete integration of claims and payment procedures into Blue Shield's computer and data processing operations.

To further standardize all aspects of communications to the medical profession during and after the period of transition, the Doctor's Record was also revised completely. It was changed in size, format and typography to permit its inclusion in a special section of the Physician's Manual. The new Record, first issued in June, 1968, was designed as a primary vehicle for updating the profession about changes in benefits, procedures, and other program content.

National Account Program for Auto Groups

A major task during the final six months of 1967 and through the first half of 1968 was the development and implementation of a master control plan for the National Account Program for Auto Groups.

While activities in this regard are continuing, the following is a summary of actions through June 30, 1968:

The Master Operating Agreement was executed with Ford and Chrysler, and that for General Motors is in the process of final execution.

Plans representing the majority of Auto enrollment for Ford and Chrysler nationally signed or were committed to sign Participating Plan Agreements. Local Blue Shield Plans will be asked to sign the Participating Agreements for the General Motors account following execution of its Master Operating Agreement with Michigan Blue Shield.

Final evaluation of the Participating Plans' Physician Payment Programs, as measured against Blue Shield's acceptable criteria, was initiated.

The Michigan Blue Shield and Blue Cross Administrative Manual was distributed in accordance with the Collective Bargaining Agreement.

The program will be effective November 1, 1968.

Other Highlights

By the end of June, 1968, regular Blue Shield programs had an enrollment of 4,567,900 members. This was an increase of nearly 365,000 over membership levels in the same month of 1967. As Blue Shield entered the second half of 1968, the corporation was servicing more than 5,536,000 people in all programs, or 63.6 percent of the state's population.

The growth of Blue Shield's activities is further reflected in the corporation's financial condition at the end of June, 1968. Assets were $91.1 million, up 12.3 percent from the same date in 1967. Liabilities for the first six months of 1968 were $36.1 million, or 1.5 percent higher than the same period in 1967.

While reserves for the first half of 1968 grew to $54,961,849, the rate of growth has decreased. In the last half of 1968, the reserves are expected to be lowered as the new MVF Program is implemented and rate credit reflecting our stable financial situation takes effect.

To keep pace with the increased volume of regular and governmental business, Blue Shield increased its employee rolls to the 1,343 mark, or more than 33 percent over June, 1967.

On January 31, 1968, the Board of Directors modified existing Master Medical programs to complement the new MVF concept. At the same time the Board authorized the marketing of MVF-1 and MVF-3 Programs to Non-Group Conversion subscribers.

The administration of the Wayne County PRESCAD drug program for pre-school and adolescent children was undertaken with the approval of the Board.

Jointly with Blue Cross, Blue Shield agreed to underwrite the Major Medical (Supplemental) benefits of the Federal Employee Program. Effective July 1, 1968, the high option program, which enrolls the vast majority of those eligible, began to be administered under the Variable Fee payment mechanism, i.e., customary and prevailing, rather than fixed fee allowance.

Management implemented plans for construction of the new Blue Cross - Blue Shield service center.

Total claims submissions in all programs were 3,733,459 for the six month period. Of this amount, on a monthly basis, actual gross receipts during the period were ahead of forecast. It is anticipated that Blue Shield claims from all programs will be in excess of 8 million at the end of 1968. Regular claims receipts during the first six months of 1968 totaled 1,857,840, an increase of more than 47,500 over total claims receipts during the same period in 1967. Medicare produced 872,000 claims during the first half of 1968, indicating a 50 percent increase in such claims over 1967. Medicaid claims amounted to 1,003,619.

Benefit payments for all programs during the first half of 1968 were approximately $108 million. Of this amount $66.5 million was disbursed under regular programs, $22.3 million under Medicare, $14.8 million under Medicaid, and $4.1 million under BS-65 complementary.

Administrative Improvements

Processing time for Medicare and Medicaid claims has been substantially reduced within the past year, and particularly during the first half of 1968.

One reason for this reduction is that more physicians (approximately 68 percent during the first half of 1968) are now accepting assignments. Additionally, fewer bills are being returned because of incomplete or inaccurate information.

About 90 percent of the assigned claims are being paid within 14 to 21 calendar days after they are received.

In addition, a computer tape listing Medicaid eligibles — furnished monthly by the state of Michigan — is easing the task of verifying recipient eligibility.

Moreover, as Blue Shield experience under these programs has increased, we have been able to refine operational techniques suited to program needs and to clarify the multitude of state and federal regulations by which they are governed.

Other Refinements

Other refinements to further reduce processing time for Medicare and Medicaid claims include:

Improved training of Blue Shield staff, greater attendance of medical assistants at Blue Shield meetings around the state, and the submission of more accurately prepared claims.

The installation of a special electronic unit to permit direct-line computer communications with Social Security Administration headquarters in Baltimore and Blue Shield's resultant capability of receiving a response to data within 24 hours of its transmission to SSA.

Industrial engineering modification of Blue Shield claims processing systems and procedures, installed earlier this year, permits a greater degree of control over claims processing despite substantially increased volume.

Plans were finalized for the introduction of plastic ID cards to allow for simpler and more accurate eligibility identification, with implementation to be effective late in 1968.

Management has established a special Systems Evaluation Group whose purpose it is to react to future identifiable growth patterns. For example, a claims volume of over 10 million is forecast for 1969, and nearly 20 million by 1970.

While Blue Shield is adjusting to this enormous increase in volume, it will also be expected to keep its administrative costs at minimum levels.

This combination of needs has already underscored for Blue Shield management the necessity of designing a comprehensive "system" which will be flexibly responsive to this accelerated growth and will result in improved performance, in terms of service and costs, in all aspects of our business.

The Group's objectives are to reduce claims processing costs, shorten processing time requirements, simplify claims handling, increase claims accuracy at their origin and during processing, and establish positive processing control guidelines.

Particular attention is being given to a more sophisticated method of data transmittal from the point where care is rendered so as to reduce paper work outside of Blue Shield as well as within its structure.

Blue Shield has structured and staffed a new Medical Affairs Division which provides, for the first time, a divisional level source for staff support to management on matters affecting medical involvement.

Utilization Review Research Project

Since the inception of this project in 1967:

The project is now fully staffed and has moved into an operational phase following its initial research activity.

Activities undertaken and implemented during the first six months of 1968 include a pilot study to determine the feasibility of accumulating research data on a subscriber or user basis . . . . the beginning of analysis and programming to build a research tape record . . . . compilation of a history tape, based on selected data from the period 1959-1967, to provide a base for comparing past patterns and profiles for use in future studies.

This project is divided into three phases:

First, it will develop and demonstrate the use of computer screens for selecting cases for review by peer groups in hospital and medical settings.

Second, it will undertake the statistical development of pattern analyses and profiles from routine claims data for use by physicians and other providers.

Third, it will involve special research study projects, suggested by the Utilization Medical Advisory Committee, which will be helpful to the medical profession.

Utilization review activity, in particular the research project, leans heavily on advisory talent of both the professional and technical type.

House Resolutions: Blue Shield Actions

While many of the resolutions adopted by the House of Delegates in 1967 were of specific interest to us, only the following required Blue Shield action:

Number 32 concerning, "Participation in Michigan Medical Service:" This resolution was reported to the Blue Shield Board of Directors in July, 1968. A study is now under way to determine the effect of per case participation on the overall participation program. Until the study is completed, action on the resolution would be premature.

Number 33 concerning, "Blue Shield 'Action Line' for Medicare-Medicaid Cases:" Michigan Blue Shield's reaction to this suggestion occurred in the fall of 1967. A special handling section was established for the processing of status inquiries. The staff of the Personal Services Department was increased to render better service, and the number of Professional Relations and Telephone Service representatives was increased. In April, 1968 a new, modern Telephone Service area was constructed in the home office to speed internal handling of physician's calls. In addition, a member of the Public Relations staff was assigned to coordinate the handling of especially urgent or sensitive inquiries, and to expedite their processing in cooperation with other Blue Shield departments.

Number 36 concerning, "Proposed Blue Shield Benefits for Sterilization." This resolution was studied by the Medical Advisory Committee throughout the first six months of 1968. It recommended the inclusion of male and female sterilization, on an inpatient basis only, in the surgical benefits of the M-75 Program. This recommendation was approved by the Board of Directors at its meeting of July 19, 1968.

Audits and Reviews

The degree to which Michigan Blue Shield is susceptible to auditing and review of its business operations and activities by a variety of external agencies is not commonly known. Yet, figuratively speaking, Blue Shield's business is pursued in a fishbowl-like environment and is subject to continuing official scrutiny.

External audits are conducted on a regular basis under nine different program headings which cover comprehensively all aspects of the corporation's program activities. Separate audits are aimed at program areas in which Blue Shield functions jointly with Michigan Blue Cross.

These auditing agencies include the Social Security Administration and the Medical Services Administration, both of the Department of Health, Education and Welfare, Michigan Department of Social Services, Federal Civil Service Commission, U.S. Army - Defense Contract Audit Agency, Internal Revenue Service, Project PRESCAD officials, the Wayne County Board of Auditors, auditors representing various Employer Groups, the National Association of Blue Shield Plans, and Blue Shield's prime regulatory agency, the Michigan Bureau of Insurance.

In addition, analyses are underway by the State Legislature with respect to Medicaid costs.

The type and scope of audit involved varies from an examination of balance sheets and statements of operations, covering all operational phases, to the specific auditing of administrative expenses, building occupancy costs, rate increases, and the testing of claims payments to physicians and the determination of reasonable physician charges.

During the last six months of 1967 and the first half of 1968 we were audited or reviewed formally on ten different occasions by agencies or organizations indicated above.

This was in addition to audits performed routinely by Blue Shield's own external auditors and its internal audits department. Also, innumerable informal visitations have occurred from these and other agencies interested in our performance and techniques of administration.

Such accountability is a fact of business life to which Blue Shield management responds not simply with equanimity, but with increased awareness of its many responsibilities.

The Future

The medical economics climate continues to demand that Blue Shield demonstrate with increased effectiveness the viability of solutions of medical care problems achieved and planned in the private sector. Effective responses will not be possible without the positive cooperation of the medical profession, nor without equal support from the consumer, especially in dealing with the problems of medical care costs.

It is required that the improved performance of the voluntary prepayment system — the major target of the new Blue Shield Systems Evaluation Group project — become an increasingly preferable alternative to further and probably more far-reaching government involvement in the health care field.

In the months and years ahead both medicine and Blue Shield will be presented with new opportunities for growth and new challenges to undertake change.

The reasonable application of the variable fee concept and its prudent control are of vital concern to the future climate of medical economics and to the voluntary character of our involvement. This also involves heavy participation by the medical profession, both within the Blue Shield structure and outside it.

Michigan Blue Shield's Utilization Review Research Project, as it develops and refines new techniques and methods of utilization analysis, will provide the medical profession with valuable new tools for retaining initiative in this sensitive area.

New benefits — already negotiated in the auto industry, and to be followed by other groups, will begin to make an impact on Blue Shield activities in 1969 and in the 1970's.

Drug benefits, implementation of which will begin in the auto industry in 1969, will be gradually extended to non-autos groups beginning in 1970.

Only a limited marketing of the Home and Office program is now anticipated until 1972.

Assumed effective dates for implementing other new benefits — Physicals, Well Baby care, and Eye Refraction services — have been tentatively set to begin also in 1972.

We anticipate that in the five year period beginning in 1969 there will be a tendency for enrollment in nonmotors groups to rise at a higher annual rate than the auto groups, primarily because of changing employment growth patterns.

There will be changes, too, in Medicare and in Medicaid. Although the precise nature of these is difficult to foresee, it is to be expected that some switching of benefits from Title XIX to Title XVIII will occur.

While the impact of these probable changes cannot be known, we expect, in general, that overall growth of Blue Shield business will be reflected in increased payout to physicians and in the development of programs appropriately responsive to patient needs. We expect a growing negative reaction on the part of the public generally to rising medical care costs. We also anticipate greater difficulty in assuring the public that we are responding adequately to its concern about costs.

In view of these expectations, management is committed to focus its efforts even more positively upon those present realities and future needs of medical economics on which the overall effectiveness of Blue Shield programs must be based.

THE REFERENCE COMMITTEE on Health Insurance & Medical Services, R. E. Rice, MD, Chairman, noted that the report was comprised of the annual report of Michigan Blue Shield to the House of Delegates along with supplementary information in the form of the Annual Report for 1967 and the information contained in the handouts entitled "Michigan Blue Shield Variable Fee Payment Mechanisms."

The Committee recommends that the substance of this report be distributed to every physician in Michigan involved in health care and to any other interested party.

This report reveals a massive capacity to provide for monumental changes within a very short time. We can be grateful that this is so. Furthermore, we can expect that this capacity will be sufficient for greater requirements that obviously will be present in the future in the payment mechanisms for providers of health care.

The Committee would like to convey its impression that corporation has responded well to the needs of the patient in a manner compatible with the ethos of the medical profession.

Our Committee feels these reports should be received enthusiastically for information.

THE HOUSE adopted the report of the reference committee.

REPORTS OF THE COUNCIL

15. Remarks of the Council Chairman — Robert J. Mason, MD

The Annual Report of The Council in your Delegates Notebook outlines major areas of concern and the action taken by The Council in exercising its leadership responsibilities. My remarks today concern pertinent actions of The Council since the report was printed. In addition, I will make some personal observations and will call upon Finance Committee Chairman Whiteley and Treasurer Ylvisaker for some comments.

As you are aware, the full Council meets eight times a year in regular session, with special sessions as necessary. An MSMS Councilor spends approximately 17 days each year on Council business.

The Council reviews minutes of all committees and takes definitive action on them, as well as reviewing the annual summaries of these committees. Because The Council is a large group and many of the matters coming before it require detailed study, The Council is organized with three standing committees: Finance, with Robert K. Whiteley, MD, Detroit, as Chairman; County Societies, with John J. Coury, MD, Port Huron, as Chairman; and Publication, with Brooker L. Masters, MD, of Fremont as Chairman. These three Committees serve as pre-study or reference committees; they make recommendations to The Council on items referred to them. I only outline this to emphasize the fact that detailed study and deliberation is given to every action of The Council.

The Council also is aware of the concerns of the individual members of MSMS, the component societies and specialty organizations composed of MSMS members.

I need not outline for you, I am sure, the many continuing problems facing medicine. The House of Delegates, as you know, sets the policy on these matters and The Council implements policy on a month-to-month basis.

Last year, and for several previous years, the House of Delegates instructed The Council to develop a model Single Medical Practice Act. This model Act was developed by the Legal Affairs Committee; copies have been sent to the delegates and to The Council.

The Council makes no recommendation to you regarding its adoption, but wishes to remind you that this is a highly technical document and requires thorough study so that the implications and ramifications of the rather precise language are fully understood before this House adopts or amends the proposed Single Medical Practice Act. I am sure you will seek the advice of MSMS Legal Counsel, representatives of the State Board of Registration in Medicine and, of course, members of our Legal Affairs Committee during your deliberations.

Another matter of concern in recent years has been professional liability insurance. Last year, you will recall, The Council issued a white paper on this matter to inform the members of the growing problem of malpractice claims in Michigan. The situation, as predicted, has steadily worsened, to the extent that The Council instructed its insurance advisor to make a thorough study of the malpractice field and give his recommendations on what course of action MSMS could or should take.

Briefly, he recommended that MSMS consider initiating a Society-sponsored professional liability insurance plan. The Council instructed the Professional Insurance Committee to thoroughly investigate this proposal and to present its recommendations to The Council. The report of the Committee, which was received by The Council yesterday, is as follows:

Special Report on Professional Liability Insurance

As instructed by The Council this Committee has investigated the proposed program of MSMS-sponsored professional liability insurance as presented to The Council in July by Insurance Counsel Stratton and Employers' Group of Insurance Companies.

The Committee invited similar proposals from the 28 largest multiple life casualty companies of which 23 replied that they would not be interested in offering a sponsored plan. The remaining 5 companies did not reply.

Finally, discussions were held with representatives of the Employers' Group and the Medical Protective Company. Our investigation disclosed the following facts:

1. Approximately 80% of MSMS members are now insured by the Medical Protective Company.
2. Medical Protective has found it necessary to decline many new applications from Class 5 physicians (these include Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists-Plastic Surgery, and Plastic Surgeons).
3. Medical Protective has also found it necessary to discontinue the writing of physicians who practice in some remote areas of the upper peninsula.
4. Medical Protective is not interested in becoming involved in a MSMS-sponsored plan nor would it oppose any actions by MSMS to sponsor a plan with another carrier.
5. The A. M. Best Company, a well-recognized rating organization, shows a decline in the ratings of the Medical Protective Company as follows:

Year	Rating*
1964	A
1965	A
1966	B+
1967	B+
1968	B

*Best's highest rating is "A Plus" and this denotes a general policyholders rating of "Excellent." Ratings vary from "A Plus" (Excellent) to "C" (Fair). The ratings used herein were taken from the latest Best's Guide. A higher rating indicates greater ability to meet present and future obligations.

6. The Employers' Group of Insurance Companies has successfully engaged in a Florida Medical Association sponsored plan of Professional Liability Insurance since 1962.

   The experience of the Florida Medical Association with Employers' was thoroughly researched by Richard Campau, the Committee staff assistant. He reported that Florida Medical Association is extremely happy with the performance of Employers' Group especially in regard to the following points:

   A. Aggressive claims defense on a statewide basis.
   B. Excellent cooperation in claims defense through committees of the Florida Medical Association and its component county societies.
   C. Educational programs for physicians as to underlying causes of claims and how to avoid them.
   D. Premiums have been kept competitive with other carriers.
   E. No physicians have been denied coverage because of specialty or location of practice.
   F. Outstanding defense counsels have been retained.
   G. Employers' has maintained the plan on a sound experience rating basis.
   H. The Company has provided the Association with complete information concerning claims and settlements.
   I. The Employers' policy specifically states that professional liability includes service by the individual insured as a member of a formal accreditation or similar professional board.
   J. In addition to its basic professional liability policy, Employers' also offers an "umbrella" type liability insurance at a reasonable premium.

Based upon the above findings and other information the Committee has concluded as follows:

1. The policy proposed by Employers' is broader and meets the needs of MSMS members better than that issued by Medical Protective.
2. The A. M. Best rating of Employers' is A Plus whereas the same organization now rates Medical Protective as B. The higher rating of Employers' indicates its greater ability to meet present and future obligations. Employers' is an organization with assets of over 400 million dollars while Medical Protective has assets of less than 20 million.
3. Employers' would establish a close liaison with MSMS to work toward an improved medico-legal climate.
4. Employers' would vigorously defend groundless claims.
5. A much more stable market would be available from Employers' than now exists. There would be no rejections or terminations because of specialty, geographical location or age.
6. Premium rates offered by Employers' would be competitive to those of Medical Protective.

The Committee is not able to make any recommendations to The Council at this time because Employers' cannot provide a specific premium quotation as professional liability rate changes involving most carriers are pending with the Michigan Bureau of Insurance. It is the intention of the Committee to submit its recommendations just as soon as the premium situation has been clarified.

We do not have the information required to make a firm recommendation to this House at this time. Therefore, The Council recommends that the House authorize The Council to complete negotiations for an MSMS-sponsored program of professional liability insurance if it is determined that such a program would best serve the interest of MSMS members. Such authorization will mean that the House has expressed its approval of the general concept of a Society-sponsored plan and will leave the detailed negotiation to be conducted by The Council so that the plan can be instituted without waiting for another 12 months when this House will meet again.

Since the special session of the House of Delegates in February, The Council has supervised every detail of the implementation of the new Asset Management Plan. We have faithfully followed the plan as adopted by the House, and I believe the report of your Treasurer will be of extreme interest. The Council certainly compliments Treasurer John Ylvisaker for his devoted leadership.

As I have told you, one of the key committees of The Council is the Committee on Finance, chaired by Dr. Whiteley. Dr. Whiteley will present a brief picture of our financial condition and then will introduce Treasurer Ylvisaker. Following Dr. Ylvisaker's presentation I would like to make some personal remarks to the House.

ROBERT K. WHITELEY, MD: 1968 has not been the most stable year in our nation's economy, as I am sure your office practice indicates. It has been a difficult year for MSMS, too. The cost of doing business is up; income is up; increased expenses are outpacing income.

Fortunately, MSMS three years ago had the foresight to initiate a modern, efficient, intelligent money management plan which gives the Finance Committee and The Council the ability to exercise rigid budget controls. The effectiveness of this plan is evidenced by the fact that actual expenses last year were within 1 per cent of budget. The Financial Structures Committee of the House has made a thorough study of our financial condition and a copy of that report has been distributed to you. We have projected our budgets for 1969 and 1970 and the results of those projections are in the Financial Structures Committee report.

I don't believe I should in a verbal report such as this give you just a bunch of figures. I will be prepared to discuss any detail of the budget and our income statement at the reference committee meeting. I do want you to know, however, that the Finance Committee and its professional consultants are prepared to meet the Internal Revenue Service regulations regarding the reporting of *Journal* advertising income. We believe that the formula for allocating expenses and income, developed for us by the Alexander Grant Company, is adequate to meet IRS demands. We are similarly prepared following the publication of guidelines for reporting exhibit income.

Now I would like Dr. Ylvisaker to give you more details about the Asset Management Plan.

Report of the Treasurer

My report this year is in two major parts and concerns itself with:

I. The Asset Management Program adopted by The House of Delegates in Special Session, February, 1968.

II. The financial condition of MSMS.

Part I

In brief review, the new Asset Management Program adopted by the House authorized the following:

1) Mortgaging of the MSMS headquarters building in an amount up to $650,000 at 6¼% interest, 25 year term, free of mortgage fees and prepayment penalties.

2) Application of the resultant monies a) to eliminate short-term line-of-credit borrowing for operational expenses, b) to increase existing reserves of $125,000 to $250,000 and thereby to establish a permanent Capital Reserve Fund with specified guidelines for use and maintenance, and c) to establish a Capital Protection and Creative Reserve Fund with the balance of the proceeds, the purpose of which would be to provide funds for other-than-ordinary services to the Society and for creative Society projects consonant with the stated aims and objectives of the Society.

3) Establishment of a Board of Managers consisting of five members with authority to invest and manage the Capital Reserve Fund and the Capital Protection Fund, subject to basic control by The Council.

4) Investment of funds as follows:
    a) Capital Reserve Fund — 50% in fixed dollar maximum yield money instruments and 50% in high grade negotiable securities to provide stability, income and conservative growth.
    b) Capital Protection and Creative Reserve Fund — 100% in bona fide investment vehicles to provide growth within the limits of sound fiscal judgment and income appropriate to such growth.

Subsequent to this authorization, The Council and your Treasurer proceeded with the implementation of this plan. The mortgage was closed with the Michigan National Bank in March. The Council then established a Board of Managers consisting of five members:

John R. Ylvisaker, MD, MSMS Treasurer	Term 1 year
Robert K. Whiteley, MD, Chairman, Finance Committee	Term 1 year
Ross V. Taylor, MD, physician representative	Term 1 year
C. Allen Payne, MD, physician representative	Term 2 years
Thomas H. Wagner, investment counselor	Term 1 year

The Board of Managers met on four occasions to transact necessary business including:

1) The establishment of a specific and objective format of operation.

2) The designation of Merrill Lynch, Pierce, Fenner & Smith, through its Institutional Department, to provide advisory service and act as official investment broker.

3) The investment of the $125,000 existing reserves in 6¼% certificates of deposit.

4) In May the investment of the first mortgage draw of $125,000 in a balanced portfolio of high yield stocks with conservative growth orientation to complete the requirements for the Capital Reserve Fund.

5) In late June, the investment of the second mortgage draw of $100,000 in growth-oriented stocks and high yield bonds to initiate the Capital Protection Fund.

6) The investment of the third mortgage draw of $100,000 in growth-oriented stocks in September to enlarge the Capital Protection Fund.

Procedurally, the Board of Managers reports regularly to the Finance Committee which, in turn, reports its findings and recommendations to The Council for information and action where necessary. Minutes of the meetings of the Board of Managers are open to both bodies.

At present the funds have substantial gains which provide the Society with additional security.

Part II

I should like to discuss the financial condition of the Society from two standpoints: the present and the future.

With the new asset management program we are in a period of transition and are converting to what might be called a budgeted, pay-as-you-go program for annual operations backed by actual reserves adequate to our present needs. Ignoring the intricacies of this transition, we are now operating within our actual income. For 1968, our income from dues and other sources covers our expenses with a modest surplus to apply on our previous borrowings.

Henceforth, however, we are bound by a budget. We may no longer finance increased expenses with unprogrammed line-of-credit borrowing. We must live within our income. To accomplish this, we must project our budgets, we must program our projects, we must tailor our expenses to fit our income or increase our income to cover increased expenses.

Without any dues increase, our income expands at a relatively predictable rate of 1% per year. Without any new projects, our expenses increase at an average rate of 4-5% per year. Our tentative projects for 1969 and 1970 confirm these rates. Therefore, with good management and no new obligations we can operate without an increase in dues for 1969. However, let me repeat and emphasize: If we embark on new programs or assume new financial obligations, the cost must be counterbalanced by 1) reduction of existing expenses or 2) an increase in dues. The amount of increase of dues will be in direct proportion to the costs incurred. With approximately 8,000 members a $10 increase can produce only up to $80,000.

As an individual, I am strongly in favor of our Society initiating and supporting aggressive, positive, imaginative programs to ensure the best quality of medical practice, the most efficient distribution, the most equitable regulation, and the most reasonable cost of medical care in the nation. To accomplish such objectives our Society must review the status of present programs to ascertain effectiveness and productivity in relation to cost. As your Treasurer, I recommend such action.

MSMS must also be prepared to finance new creative projects. The establishment of the Capital Protection and Creative Reserve Fund I sincerely believe will become one of the greatest forces in fostering and supporting such projects in the coming generation.

ROBERT J. MASON, MD:

You have all received a copy of the workbook, *Where We Stand*, 1968. Just as its predecessor did last year, this document challenges our interest by discussing the opportunities, responsibilities and problems of our profession in the changing environment in which we practice and in which our organization functions.

Earlier I told you that a Councilor spends an average of 17 days on Council business. Yet this does not truly indicate the extent of his participation. It does not reflect the study time, the thinking time, and travel to and from meetings, which eat into a daily schedule. But these elected officers of yours deserve special praise. As Chairman of The Council, I know just how important their contributions are. I express to them, the Councilors and officers of MSMS, my sincere appreciation for their leadership and cooperation during this past year.

Our leadership responsibilities are greatly facilitated by fine staff efforts. In addition to the staff's management function, our executive, senior and secretarial staff provides background and planning help for all MSMS committees, Council committees, House of Delegates and your officers.

I want to praise the members of this House of Delegates for its policy guidance in the past. I am confident that your deliberations today and tomorrow will provide appropriate policy to meet the problems that medicine faces today.

(HOUSE action on this verbal report follows the Annual Report of The Council, see page 22.)

16. Annual Report of The Council

PART I

Report of Council Activities

This section of the report contains a brief review of the activities and actions of The Council covering the period from September 1967 through July 1968.

Minutes of the regular meetings of The Council are distributed to component medical societies and members of the House of Delegates. In addition, abstracts of Council actions appear in *Michigan Medicine*. For this reason, the details of Council actions and decisions are not outlined in this review. Instead, The Council wishes to point to a few of the major achievements and problems in a general way.

MSMS Relationship with Blue Shield. The Council appointed an Ad Hoc Committee to Study MSMS Relationship with Blue Shield and asked it to recommend what future relationships should be. The Council adopted the committee's report in July.

The Committee recommended, unanimously and unequivocably, continuation of the present relationship between MSMS and MMS, and collected the following reasons in support of its recommendation:

1) The initiation of the service concept of prepaid medical care was made by physicians of Michigan. Though there have been many changes associated with the growth of MMS over the years, the basic philosophy behind this program seemed to the Committee to remain on solid ground. It is our opinion that, while admitting that areas of dissatisfaction do exist, as with any large scale operation, in general the consumer, the purveyor and the fiscal agent have cooperated to provide a workable, generally beneficial method for servicing and financing health care in Michigan.

2) The occasional situation which has led to concern for MSMS continuing its relationship with MMS has usually been due to faulty or inadequate information and communication and/or the changing format of coverage.

The Novy report of 1960 re-established certain fundamental relationships which had become distorted. Since that time there developed a lack of adequate liaison which ultimately led to the creation of this Committee. It is to be noted that recent efforts have been made by both organizations to rectify the deficiencies and an increased awareness has developed to support the idea that we are dependent on each other's good will. With this fact your Committee heartily concurs, believing that it is more imperative than ever to further this good will relationship — with the public good our greatest concern.

3) Quoting from written notes submitted by committee members, the following comments in support of the Committee recommendation are presented:

"The Board of Blue Shield . . . consists of public lay members and representatives of medicine." It "represents the interests of its three million or so subscribers and the physicians of Michigan who provide service to the subscribers . . . The board . . . is highly sensitive to the needs of the subscriber and to the needs of the physicians of Michigan."

"The public wants and demands voluntary health insurance. This includes individual groups and large purchasers of health care. It is here to stay."

"If the medical profession through Michigan Medical Service does not provide these services — a void or vacuum will be immediately created in this vital area of providing medical care."

(These) "basic groups, namely government, private insurance carriers and hospitals (via Blue Cross) or a possible combination of all three will take over the health carrier role and set fee schedules."

"There should be an ongoing continuing investigation of the economic relationships of Blue Shield and the Michigan State Medical Society and the future role of these in the practice of medicine in Michigan."

Finance. Inflation and the generally higher cost of doing business have had a limited effect on the MSMS financial picture. Fortunately higher costs have been partially offset by increased income. This plus careful control has produced a balanced budget in fiscal 1967 and a balanced budget is predicted for fiscal 1968.

1968 has been a changeover year, during which MSMS is embarking upon the new Asset Management Plan approved by the House of Delegates meeting in special session in February. Treasurer Ylvisaker, the plan's architect, has received the highest praise from The Council for his fine work in developing the plan and in implementing it following House approval. Doctor Ylvisaker will present details of the plan's implementation status in a direct report to the House.

It is impossible to know what the next budget year will bring. We can be sure of some inflation and higher costs, especially in services. The Council, as it develops its 1969 budget, will watch closely all planned expenditures and still maintain the required and desirable level of MSMS services.

Membership. Total membership in MSMS from 1935 to 1968 was:

Year	June 30	December 31
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1966	7296	7710
1967	7301	7858
1968	7617	

Liaison with Specialty Groups. Recognizing an opportunity to be of service to the various organized medical specialty organizations, The Council appointed an ad hoc committee to review these needs. The committee will make recommendations to The Council in the near future.

Streamlining of MSMS Committees. Upon the request of the House of Delegates Committee on Constitution and Bylaws, The Council is reviewing the necessity for continuation of some committees and considering the possibility of combining or eliminating the inactive committees. Currently under study is the possibility of enlarging the scope of the Public Health Committee to include disease problems that up to now have been the concern of separate committees.

Legal and Governmental Affairs

A significant portion of the deliberations of The Council at each of its meetings concerns matters directly related to activities of the legislative, executive and administrative branches of state government and to consideration of developments related to federal health programs or congressional action.

Several members of the MSMS staff constitute a "governmental relations" team which, heavily utilizing necessary socio-economic and legal consulting personnel, are responsible for keeping The Council currently informed of significant health developments in the public sector. Perhaps most visible to the membership in this general area is the work of the Legal Affairs Committee through its news organ, "Medigram," closely followed by the Governmental Medical Care Programs Committee which frequently prepares information for publication in *Michigan Medicine*. More detailed descriptions of the activities of both these hard-working committees are contained in their Summaries of Activities as presented to the House of Delegates.

Ongoing and important work is also done, however, by such liaison committees as those with the State Executive Office, the Board of Registration in Medicine, the Mental Health Committee, the Public Health Committee and numerous liaison committees with such groups as nursing, pharmacy, podiatry, etc., all relating to gathering information for Council review or implementation of MSMS program and policy.

"Governmental relations" constitutes a total activity which increases in complexity with the passage of time, not only because of proliferating programs in the health field but because of the concomitant necessity of constantly striving to improve relationships between medicine and its allies both in the health field and in the total state community. The MSMS legislative experience in the past year has been highly successful. In addition, as our "governmental relations" staff gains experience and increases its knowledge and contacts, MSMS is steadily improving its capacity to anticipate developments, work with appropriate officials, and guide programs along the lines of Society policy as established by the House of Delegates.

Comprehensive Health Planning. Last August Governor Romney issued an Executive Order creating the Comprehensive State Health Planning Commission, to be located within his office. This body closely parallels, in basic concept, recommendations previously made to the Executive Office by The Council and the Committee on Governmental Medical Care Programs. They advocated that a plan-for-planning group be formed to formulate plans for submission to the Surgeon General for implementing this program in Michigan. Chairman of the Commission is R. G. Rice, MD, Director of the State Department of Public Health. Charles Orlebeke, an executive assistant in the Executive Office, is Vice-Chairman. Other Commission members include William H. Anderson, MD, State Mental Health Director, R. Bernard Houston, Director, State Social Services; Glen S. Allen, Jr., State Budget Director. Mrs. Betty Tableman, formerly on the staff of the State Public Health Department in Planning, was appointed Executive Director in March, 1968. Mrs. Tableman will be working under the direction of the Commission with responsibility for a continuing planning operation to identify health needs, problems, objectives, and priorities and to make recommendations for allocation of funds. Full implementation of this program has not begun, due to the difficulty of the Executive Office in appointing the required Comprehensive State Health Advisory Council. The function of the Advisory Council will be to advise on the planning process; membership must include more than half consumer representation as well as voluntary groups, physicians, public agencies, general planning agencies, and universities.

Michigan Conference for Health Planning. A new meeting, the "First Annual Michigan Conference for Health Planning and Related Subjects," was sponsored by MSMS in Detroit in February, 1968. This Conference was designed to serve MSMS members by providing authentic information by experts in several fields. The Conference revealed MSMS leadership in the critical areas of legal and legislative affairs, and medical manpower and health care planning. Major subjects covered included: The Doctors, The Law and The Courts; Legislative Affairs; Health Planning as It Affects the Physician, Hospital and Community; Comprehensive Health Planning; MARMP — Heart, Cancer and Stroke; and Public Education through a Quackery Conference. The response to this three-day conference was good and tentative plans are to continue these seminars in the future.

Michigan Association for Regional Medical Programs. MSMS has increased its involvement in the important plans for implementation of the heart-cancer-stroke program through MARMP. MSMS continues to receive the dedicated service of Don Marshall, MD, an MSMS Councilor who is Vice-President of the Board of Directors of MARMP. This federal program has made notable progress in the planning process in education and training. It is intended to 1) identify regional needs and resources relating to heart disease, cancer, stroke, and related diseases, and 2) to develop a regional medical program which utilizes regional cooperation to apply and strengthen resources to make more widely available the latest advances in diagnosis and treatment of these diseases. A regional advisory group representing university medical centers, hospitals, practicing physicians, other health professionals, voluntary and public health agencies, and members of the consumer public, will play an active role in the development of the regional program and will approve applications for operation activities of this program.

Medical Economics

Annual Revision of Michigan Relative Value Study (1965). The Committee on Relative Value Study has made revisions in the Neurosurgery, Anesthesiology and Radiology sections of the Michigan RVS. These changes will be presented for final approval as part of the Committee's 1967-68 annual report.

The Committee will also recommend that its work be continued because the RVS is a valuable reference for physicians, especially with the growth of "variable fee" type insurance and prepayment health programs.

Long-Range Planning. This project of the Committee on Medical Socio-Economics is progressing. Position papers, in which experts describe the challenges, in their view, that medicine will face, are being published in *Michigan Medicine.*

The Council is pleased to report that Charles Hall's paper on the future of health insurance and prepayment was selected by a jury representing the American Medical Association, the American Medical Writers Association and the National Association of Blue Shield Plans as the most scholarly contribution to the literature of medical economics for the year ending June 30, 1967. Doctor Hall was presented the Norman A. Welch, MD, Award by the NABSP for his achievement.

After all the papers are published, the Committee will conduct workshops throughout the state to focus attention of component medical societies on the future. This activity is intended to stimulate the development of new MSMS approaches and programs to meet the challenges of the future.

Fee Survey in Wayne County. The Council approved a request from the Wayne County Medical Society for a survey of fees in Wayne County. Work on this survey has begun and the information obtained should be of significant value to physicians, not only in Wayne County, but throughout Michigan.

Courses on Medical Economics and Ethics. Lectures on medical economics and ethics were continued at the University of Michigan Medical School under the sponsorship of the Committee on Courses on Medical Economics and Ethics. This Committee will continue its efforts to initiate similar programs at Michigan State University College of Human Medicine and Wayne State University School of Medicine.

Adoption of New Blue Cross and Blue Shield MVF-2 Package Program. The Council on June 5, 1968, approved the recommendation of the Committee on Professional Insurance Plans that MSMS adopt the new Blue Cross-Blue Shield MVF-2 package. This program replaces the present M-75 and Over-65 group health programs now available to MSMS members. It offers an expanded scope of benefits and is effective as of August 1, 1968.

Improvements in the MSMS Group Disability Insurance Plan. Several improvements in the MSMS Group Disability Plan were worked out by the Committee on Professional Insurance Plans and the Provident Company. These include: a) reduction of premium for the lowest age group (under age 34), b) an increase in the available maximum indemnity from $500 to $1,000 monthly, c) an insurability guarantee provision, d) an extension of the disability benefit period for members under age 50 who become disabled because of sickness from age 65 to lifetime.

Disability Insurance for Employees of MSMS Members. This new group insurance program was developed by the Committee on Professional Insurance Plans. This plan is underwritten by the Provident Life and Accident Company and went into effect April 1, 1968. It provides monthly cash benefits for enrolled employees of MSMS members who become disabled because of accident or sickness. A choice of a one-year accident — one-year sickness plan or a five-year accident — two-year sickness plan is available.

Medical Problems of Disadvantaged in Cities. The Council feels a deep concern that all people have an opportunity to share in the American dream of being able to better oneself by individual initiative and hard work. To this end it has appointed a committee to identify any unmet medical needs that exist among the disadvantaged in our cities and to make appropriate recommendations for MSMS action programs to meet these needs.

Updating of Statement of Principles for Lawyers and Physicians. The Council approved a recommendation of the Liaison Committee with the State Bar of Michigan that the "Compensation for services of physicians" section of the present agreement between MSMS and the State Bar of Michigan be revised to state "it is the responsibility of the attorney to pay the physician a reasonable fee for services rendered" in cases where the physician aided in preparing a case. The Medico-Legal Committee of the State Bar is pursuing approval of this change by the governing board of the State Bar.

MSMS Sponsored Plan of Professional Liability Insurance. The Council, at its July meeting, directed the Committee on Professional Insurance Plans to investigate the advisability of MSMS sponsoring a professional liability insurance program, and to report prior to the next meeting of The Council. The Council pointed out in its directive that the Committee should have discussions with the Employers' Group of Insurance Companies, the Medical Protective Company and other carriers. This investigation is underway and a full report will be made by the Committee to The Council prior to its September 22 meeting. Any recommendation to the House will be presented verbally in the Chairman's Report.

Postgraduate Education

MSMS continued to provide many postgraduate educational experiences for its members while studying possible ways to update and improve techniques and methods.

1967 Annual Session. Topics of importance to the everyday practice of MSMS members were covered by medical authorities at the 1967 Annual Scientific Session in Grand Rapids.

Michigan Medicine. This official journal offered excellent original scientific papers (mostly by Michigan men about Michigan procedures and practices) in each issue. John W. Moses, MD, Detroit, was appointed in May as the new Scientific Editor, to succeed George H. Lowrey, MD, Ann Arbor, who resigned after completing a productive term of service.

Fall and Spring Programs for Component Medical Societies. During the fall of 1967 and the spring of 1968 MSMS provided postgraduate programs throughout Michigan except for the Detroit metropolitan area. A total of 39 faculty members from the three Michigan medical schools provided 37 programs in 20 selected centers, with most centers having both a fall and spring program. The educational value of these programs was further improved this year as more communities added afternoon clinical conferences at local hospitals to discuss actual cases. The Committee on Postgraduate Medical Education during the year sought to develop some approach to determine exactly what the physicians would like to have offered, and to find out how they continue their education.

Special Conferences. To further meet its responsibility in postgraduate medical education, MSMS sponsored the Seventh Annual Conference on Maternal and Perinatal Welfare; the Annual Diet Therapy Conference in Grand Rapids; and cooperated in presenting other programs for physicians.

The Conference on Maternal and Perinatal Welfare, sponsored by the MSMS Committee on Maternal Health, with financial assistance from the Clara Elizabeth Fund, was held March 26-27 in Flint. It was an outstanding success.

Under the capable leadership of Chairman Jack W. Thompson, MD, of Flint, and his committee of Flint physicians, this year's postgraduate meeting for those persons interested in the care of the mother and her child drew a total registration of 352 — 185 doctors of medicine, 22 osteopaths, 108 nurses, 20 students and 17 guests. All in attendance highly praised the excellence of the speakers and the subject matter presented.

Professional, Public and Legislative Relations

This report highlights some major MSMS efforts in the area of relationships with the profession, the public and the Legislature. MSMS has varied activities to communicate its concerns to special selected audiences and the people of Michigan.

Liaison with Component Societies. MSMS has had effective on-going communications with leaders of the 55 component medical societies. During the fall, a traveling "faculty" of MSMS officers and staff members held workshops in four regions of the state, to inform component society officers and other leaders about actions of the 1967 House of Delegates, and to discuss current projects and problems. Throughout the year, MSMS urged every component society to send representatives to the annual MSMS Workshop on Medicine and Religion, the annual MSMS Conference on the Medical Aspects of Michigan High School Sports, and other events. MSMS also provided information and guidance to component society leaders through *Michigan Medicine* and special letters on many subjects.

Liaison with the Michigan Association of the Professions, the Michigan Health Council, and Other Organizations. MSMS officers, committees and staff spent considerable time and effort to maintain good rapport with many Michigan organizations. Liaison was maintained with a long list of organizations, including the Michigan Association of the Professions, the Michigan Health Council, State Bar of Michigan, Michigan State Pharmaceutical Association, Student American Medical Association chapters at the three universities, Michigan Nurses Association, Detroit Medical Association, Michigan Youth Commission, Michigan Press Association, Michigan Council of Churches, Michigan Adult Education Association, Michigan Congress of Parents and Teachers, Michigan Week Foundation, Michigan Public Health Officers Association, Michigan United Fund, the New Detroit Committee and many others.

Career Recruitment. The Public Relations Committee carried out many activities to inform people and their parents of the fine career opportunities in medicine and related health fields. MSMS and the Michigan Health Council purchased their second major order of "Careers Unlimited," the AMA career handbook with eight pages of Michigan information to make the booklet especially pertinent. These booklets were distributed systematically to schools, libraries, youth groups, etc. Radio tapes, TV programs, etc., all supplemented the continuing efforts of MSMS to increase the health manpower available to serve the people of Michigan.

Health Careers Mobile. MSMS (which originated the mobile unit three years ago as a traveling museum about medical progress in Michigan) continued this past year to provide major financial assistance to the Michigan Health Council's Health Careers Mobile. New exhibits on health careers were added and others refurbished. Major highlights for the Careers Mobile were extended visits at Detroit's inner-city high schools and the appearance this spring at four metropolitan Detroit Health-O-Ramas.

Special Education Efforts. The Cancer Committee carried out a comprehensive effort to get more women to have annual Pap tests; the Family Life Education Subcommittee provided speakers for many programs about sex education; the Committee on Medical Aspects of Organized Athletics cooperated effectively with the Michigan organizations of coaches, directors of physical education and others; etc.

MSMS moved into another area of major public concern — Quackery Education; it held a Quackery Workshop in Detroit during the 1968 Conference on Michigan Health Planning, and another in Lansing for selected leaders from the Legislature, federal and state agencies, health organizations, civic groups, physicians, etc. The Council in June adopted a new program in quackery to work with schools, the Legislature, and others.

Appreciation is accorded again to the Michigan Association of the Professions and its award-winning television program, "Formula." During the past year, the Formula program utilized physicians to interpret health subjects to the viewers.

PART II

Annual Summaries of Committee Activities

The Council reviewed summaries for all MSMS and Council committees.

PART III

Matters Referred To The Council By The 1967 House Of Delegates

Single Medical Practice Act. Resolution 13, which instructed that a bill to establish a single medical practice act be prepared for introduction to the Michigan Legislature and returned to the next session of the MSMS House of Delegates, was referred to the Legal Affairs Committee.

A subcommittee of the Legal Affairs Committee is working on development of such a bill for presentation to the 1968 House of Delegates.

Financial Remuneration for MSMS Officers. Resolution 17 instructed the Finance Committee to investigate the concept of adequate financial remuneration for MSMS officers, investigate suitable means of securing the additional monies required, and make a report and recommendation on this subject to the 1968 House of Delegates.

The Finance Committee studied the entire matter, including the results of an opinion survey of past MSMS officers as to their feelings on the subject based on their experience in office.

The survey showed evenly divided opinion and no agreement on the question of remuneration as to desirability, method, amount, or who should be remunerated.

The Committee also noted that current policy provides for 1) special expense allowances of $1,000 annually for the President, Speaker and Council Chairman, and 2) reimbursement of out-of-pocket expense for authorized travel of all officers.

Although the Committee felt that officer candidates were not deterred by the expense reimbursement system, it did recognize the economic impact of some of the MSMS officer positions.

Regarding the source of funds, the Committee concluded that any major program adopted could only be financed by an increase in dues.

Lastly, the Finance Committee felt it was inappropriate for it to make any recommendations on a matter which might ultimately benefit some of its members and would therefore be self-serving.

Health Information Research Institute. Resolution 18 instructed The Council to "provide for organizational expenses incidental to incorporation of the Institute, materials necessary to present the principles of the Institute to prospective sponsors and such seed money as The Council deems necessary and available within the limitation of its present overall budget."

The Council did provide "seed money" in the amount of $5,000 for the 1968 budget year. The Institute employed two part-time people to develop plans and programs and to prepare the materials necessary to seek financing from prospective sponsors.

Reports are received by The Council from the HIRI Advisory Committee and the Executive Director, and in July The Council approved an interim progress report and authorized HIRI to solicit necessary funds. Progress reports will be regularly received by The Council.

Educational Program re Chiropractic. Resolution 31 encouraged MSMS "to initiate an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult."

Educational conferences on the broader aspect of health quackery were held in Detroit and Lansing during the past year for the public and physicians. A recommendation that there be a new ongoing "MSMS Committee on Health Quackery" to carry out an educational effort grew out of the Lansing invitation conference April 1 and was adopted by The Council in June. This committee now will seek continually to educate the public about quackery, including the cult of chiropractic.

Supporting Appropriations for Four-Year Medical School at MSU. Resolution 31 directed that MSMS support the request of the State Board of Education for an appropriation to enable MSU to expand its College of Human Medicine to a four-year medical school.

Letters indicating MSMS support of this request were sent to the Governor and other appropriate state officials, and subsequently the requested funds were appropriated by the Legislature.

Approval of Screening Programs. Resolution 35 directed that The Council limit its approval of screening programs to those previously approved by the component medical society or societies in which the program is to be carried out.

This policy was in effect prior to the time the resolution was adopted so no further action was required.

Proposed Blue Shield Benefits for Sterilization. Resolution 36 directed that MSMS through appropriate officers apprise Michigan Medical Service of the Society's opposition to the MMS restriction denying surgical benefits for sterilization procedures, and request that the restriction be eliminated.

This matter was brought to the attention of the Blue Shield Board by MSMS officers and we have been advised that MMS is studying the problem.

Medical Society Membership for Osteopathic Physicians. Resolution 39 directed that component medical societies be encouraged to offer associate memberships to osteopaths on an individual basis, and outlined provisions whereby such associate members of component societies could be admitted to associate membership in MSMS.

Component society officers were informed of the resolution and its contents by letter, and appropriate publicity appeared in *Michigan Medicine.*

Separate Michigan Department of Public Health Covering Health-Related Activities. Resolutions 42 and 49 directed that MSMS contact the Governor informing him in the most forceful way possible that MSMS supports the retention of health-related activities within a strong separate Michigan Department of Public Health.

Immediately following the House of Delegates meeting, a letter was sent to the Governor, presenting in some detail and in a forceful manner the MSMS views on this subject. The Governor felt that a merger of the State Department of Public Health and of the State Department of Social Services at present would be inappropriate.

Medical Student Preceptorship Program. Resolution 46 directed that MSMS, in cooperation with the three medical schools in Michigan and their SAMA chapters, establish a preceptorship program throughout the state.

The Council referred this resolution to the Education Liaison Committee. The possibilities of establishing a preceptorship program as requested by the resolution are under study by the Committee and representatives of the three medical schools. In effect, this is a continuing study (which has many ramifications) of a preliminary investigation several years ago by the same Committee.

MSMS Support of 1968 Student American Medical Association National Meeting in Detroit. Resolution 53 directed that The Council and staff support this SAMA convention by extending all possible cooperation.

After consultation with SAMA officials, The Council authorized a $500 program grant and staff assistance to SAMA for this national meeting.

MSMS Liaison with Students of the Health Care Professions. Resolution 54 directed that MSMS "appoint a liaison committee with students of the health care professions in order to extend the availability of medical care."

The Council requested the Liaison Committee with Residents, Interns and Medical Students to implement the intent of this resolution.

Appeal Mechanism for Unresolved Adjudication. Resolution 59 directed that MSMS establish an appropriate appeal mechanism available to either Michigan Medical Service or the physician concerned in the situation of unresolved adjudication.

After review by the County Societies Committee of The Council, The Council accepted the Committee's opinion that an adequate appeal mechanism already exists, along with a request that our knowledge of the existing machinery routinely be made available to carriers other than Blue Cross-Blue Shield.

Commendation to Vice-Speaker Hayes. Resolution 64 asked that a suitable commendation be presented to Doctor Hayes as the retiring Vice-Speaker. A framed copy of the resolution was presented to Doctor Hayes at the MSMS Conference on Health Care Planning in Detroit in February.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, 1) noted the report of the Ad Hoc Committee on Blue Shield "and agreed with their unanimous recommendation that the present relationship between these two bodies be continued. We urge that every effort to improve communications between these two groups be utilized." 2) complimented the Treasurer and the Board of Managers, 3) urged each Delegate and each component medical society make every effort to be involved in comprehensive health planning. The future of medicine for all of us is dependent on this. In testimony before the Reference Committee there was considerable feeling that an attempt should be made to amend Public Laws 89-749 and 90-174 of the U.S. Congress to increase physician representation on comprehensive health planning boards.

(4) You have all received a copy of a draft dated 9/5/68 for a Single Medical Practice Act. The Reference Committee recommends that a study committee of the House of Delegates be appointed by the Speaker to review this draft. On this committee we feel there should be representation by Legal Counsel, the State Board of Registration in Medicine, and the Legal Affairs Committee. This committee should also obtain from each county medical society a review of this draft. This committee should report to The Council of MSMS, and your Reference Committee wishes to empower The Council to approve and use the final Single Medical Practice Act as they see fit in introducing it to the Michigan State Legislature.

(5) In the supplemental remarks of Dr. Mason this morning was a report from the Committee on Professional Insurance Plans, Dr. Robert Stow, Chairman. This report deals with a proposed professional liability insurance policy to be sold on a group basis to MSMS by the Employers' Group of Insurance Companies. It is the feeling of the Reference Committee that this House of Delegates should empower the Committee and The Council to act in our behalf to obtain this group coverage once the premium quotation is obtained, if in their judgment it is in the best interest of the Society to proceed.

(6) Your Reference Committee discussed The Council action regarding Resolution 17 of the 1967 House of Delegates. The Reference Committee suggests that the Speaker of the House appoint a committee to investigate the question of remuneration of MSMS officers and report their findings to the 1969 House of Delegates.

THE HOUSE substituted for the last sentence in item 4), the following: "This Committee should report to The Council of MSMS. Your Reference Committee wishes to empower The Council to approve and use the Single Medical Practice Act as they see fit in introducing it to the Michigan Legislature." With this substitution, the report was adopted as amended.

COMMITTEE REPORTS

17. Annual Summaries of Council Committees

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE

Herbert A. Raskin, MD, *Chairman*

During the year, the name of the Committee was changed to "Committee on Alcohol and Drug Dependence."

Alcoholism. The Committee continued its liaison with the Alcoholism Program of the Michigan Department of Public Health; reviewed and made recommendations concerning alcoholism legislation; had a meeting with Bruce L. Danto, MD, Chairman of the Detroit Mayor's Skidrow Committee; reviewed continuation of the MSMS thrust on alcoholism education and agreed that committee members should serve as a speaker bureau for component societies and other related groups; will look into the program and activities of the newly formed Michigan Alcohol and Addiction Association; and soon will have a joint meeting with the Committee on Occupational Health to consider a possible statewide meeting on alcoholism in industry for industrial physicians.

Michigan Criminal Code. The Committee made a thorough study of portions of the Code concerned with alcoholism and drug dependence, and recommended that the provisions in the Proposed Revised Michigan Criminal Code pertaining to alcoholism be accepted and supported by MSMS.

The Committee recommended that MSMS support the sections in the Proposed Revised Michigan Criminal Code pertaining to narcotics with the exception that the Committee questions the justification of the severity of the penalties imposed on the possessor of marijuana.

The Council referred the Committee's recommendations to the Committee on Legal Affairs.

Drug Dependence. Copies of all available material and information on the subject of drug dependence have been obtained and studied by the members of the Committee.

The Committee held a meeting with representatives of the House Committee on Narcotics and the Subcommittee on Alcoholism Program (of the Liquor Control Commission). Representative Dale Warner, Chairman of the House Committee on Narcotics, explained the aim and purpose of his Committee was the evaluation of laws governing the equity and adequacy of controls concerned with dangerous drugs and narcotics. In Michigan there is no state allocation of responsibility to meet any of the aspects of drug dependence.

The Committee will continue its liaison with Representative Warner and his Committee.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

A subcommittee has been appointed to investigate the possibility of a physician education seminar in drug dependence; the Committee has offered to serve as a consultative group in relation to drug dependence problems to MSMS members; has recommended to the State Board of Registration in Medicine that its board be expanded to include a group of physicians, qualified in drug dependency, to serve in an advisory capacity to law enforcement agencies in any problem relating to misuse and improper dispensing of drugs by physicians; the Committee will write articles on narcotic drug use and misuse and its relation to physicians for *Michigan Medicine;* and, will review any legislation concerned with narcotics.

The Committee will continue its study of the problem of drug dependency and will keep MSMS members informed.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AWARDS

C. Allen Payne, MD

During 1967-68 MSMS continued its award program to recognize MSMS members for service to the profession and the public.

MSMS Outstanding Health Service Awards:

The MSMS Council, upon the recommendations of the Committee on Awards, selected 12 Michigan public officials, associations, firms, and foundations to receive recognition for their contributions to medicine and health. The awards were given at the First Annual Michigan Conference on Health Planning on February 24, 1968 to the following:

Clara Elizabeth Fund, Flint
Consumers Power Company, Jackson
Charles E. Forsythe, Lansing
Grand Rapids Press
Secretary of State James M. Hare
Michigan Association of the Professions
Outdoor Advertising Association of Michigan
Senator Robert L. Richardson, Saginaw
Sears-Roebuck Foundation, Chicago
Representative J. Robert Traxler, Bay City
The Upjohn Company, Kalamazoo
WJIM-TV, Lansing

MSMS Distinguished Service Awards:

The MSMS Council, upon the recommendations of the Committee on Awards, selected two MSMS members to receive recognition for their efforts to improve the health and medical care of high school and college athletes. Distinguished Service Awards, presented at the First Annual Michigan Conference on Health Planning, February 24, 1968, were presented to:

James S. Feurig, MD, East Lansing
Gerald A. O'Connor, MD, Ann Arbor

MSMS Awards to National Presidents:

As in the past, MSMS will present its National Presidents Award to MSMS members who are serving as presidents of national medical organizations. The MSMS Council approved the recommendations of the Committee on Awards to present the award to the following during the 1968 MSMS House of Delegates meeting:

H. Marvin Pollard, MD, Ann Arbor
American College of Physicians

Raymond W. Waggoner, MD, Ann Arbor
American Psychiatric Association

Edwin De Jongh, MD, Birmingham
American Academy of Occupational Medicine

Rosser L. Mainwaring, MD, Dearborn
American Society of Clinical Pathologists

John J. Hanlon, MD, Detroit
American Public Health Association

MSMS Flag Awards:

The Council, upon the recommendations of the Committee on Awards, created a new category of awards to recognize Michigan physicians who are serving as presidents of various state-wide organizations. The Council approved awards to 10 Michigan physicians. The awards, given during the First Annual Michigan Conference on Health Planning, February 24, 1968, were presented to the following:

Carl B. Beeman, MD, Grand Rapids
President, Michigan Heart Association

Donald R. Hagge, MD
President, Michigan Archeology Society

John J. Hanlon, MD, Detroit
President, Michigan Public Health Association

William N. Hubbard, Jr., MD, Ann Arbor
President, Michigan Association for Regional
Medical Programs

Benjamin Jeffries, MD, Detroit
President, Michigan Epilepsy Center and Association

George D. Maniaci, MD, Gladstone
President, Michigan Association for Retarded Children

G. Frederick Moench, MD, Midland
President, Michigan Society for Better Hearing
and Speech

John B. Rowe, MD, Flint
President, Michigan Diabetes Association

G. B. Saltonstall, MD, Charlevoix
President, Michigan Association of the Professions

H. A. Towsley, MD, Ann Arbor
President, Michigan Health Council, and
Michigan United Fund

Fifty-Year Service Awards:

The 1968 House of Delegates will recognize physicians who have served 50 years in the practice of medicine. As of September 10 the list of awards included the following — several others may be reported by component medical societies before the actual presentation on September 24:

Calhoun County:
  A. M. Giddings, MD, 104 Kicker Pl., St. Mary's, Ohio 45885
  Welcome B. Lewis, MD, 196 Irving Park Dr., Battle Creek, 49017
  William V. Vandervoort, MD, Route #4, Hastings, 49058

Grand Traverse County:
  Edward F. Sladek, MD, 123 East Front Street, Traverse City, 49684

Ingham County:
  M. S. Hurth, MD, 1717 Jerome Street, Lansing, 48912

Kent County:
  Garnet G. Stonehouse, MD, 408 Medical Arts Bldg., Grand Rapids, 49502

Menominee County:
  Karm C. Kerwell, MD, P.O. Box 17, Stephenson, 49887

Oakland County:
  Sol M. Lewis, MD, 541 West Oakridge, Ferndale, 48220

Saginaw County:
  Lloyd C. Harvie, MD, 330 South Washington Ave., Saginaw, 48607

Wayne County:
  Elden C. Baumgarten, MD, 1062 Lochmoor Blvd., Grosse Pointe Woods, 48236
  Wyman C. C. Cole, Sr., MD, 1116 Leisure Lane, Walnut Creek, Calif. 94597
  Ray S. Dixon, MD, 5001 VanDyke, Detroit, 48213
  Clyde H. Hasley, MD, 2320 North LaSalle Gardens, Detroit, 48206

William E. Hilton, MD, 5013 Harding, Detroit, 48213
Joseph A. Kasper, MD, 1011 Cadieux Road, Grosse Pointe Park, 48230
Fred O. Lepley, MD, 19799 Mack Avenue, Grosse Pointe Woods, 48236
Alton R. Marsh, MD, 15696 Woodland Drive, Dearborn, 48120
Arthur B. Norton, MD, 1077 Fisher Bldg., Detroit, 48202
Robert L. Novy, MD, 858 Fisher Bldg., Detroit, 48202
Harold F. Raynor, MD, 49 Virginia Park, Detroit, 48202
John R. Rieger, MD, 746 Pallister, Detroit, 48202
Isaac S. Schembeck, MD, 1553 Woodward Ave., Detroit, 48226
James M. Stanton, MD, 1001 Mutual Bldg., Detroit, 48226
Milton D. Vokes, MD, 10182 Gratiot Ave., Detroit, 48213
Alfred H. Whittaker, MD, 3 Elmsleigh Lane, Grosse Pointe, 48230
Now in Escondido, California:
T. P. Wickliffe, MD

THE HOUSE, based on the recommendations of the Awards Committee, did present the awards outlined in this report (see Section on Presentations and Awards).

COMMITTEE ON BEAUMONT MEMORIAL

Bradley M. Harris, MD, *Chairman*

Early this year, Mrs. George A. Brotherton, a descendant of Doctor William Beaumont, contacted the committee as to whether or not the Michigan State Medical Society wanted to purchase a silver friendship cup which once belonged to Doctor Beaumont's daughter, Sarah, who in turn gave it to her daughter Lucretia Irwin.

After studying the matter, and consulting with Eugene T. Petersen, Director of the Mackinac Island State Park Commission, the committee decided the friendship cup would be a valuable addition to the Beaumont memorabilia on the Island, because of the historical association with Doctor Beaumont.

The silver friendship cup is currently on display there. Other items in the Beaumont collection are in good condition and well displayed.

The Committee will meet July 20 on Mackinac Island to discuss further matters.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

Richard O. Kraft, MD, *Chairman*

The Committee on Courses on Medical Economics and Ethics met in Ann Arbor on August 28, 1968.

At this meeting the members reviewed the subject material presented during the preceding year to the students at the University of Michigan. A variety of topics were presented including a discussion of osteopathy, problems related to narcotics, military medicine, medicine and religion and the business side of medicine.

The Committee was most concerned about the limited attendance recorded during these sessions by senior students. In previous years and months various methods have been utilized to improve the attendance — including meetings in the evening, less frequent meetings, a change of subject material, a change in technique of presentation, all to no avail.

The Committee approved a recommendation that its chairman investigate alternate times and places in the medical students university experience for these meetings so that more of this valuable material can be presented and appreciated by more students. Included during this forthcoming "trial year" will be presentations to the freshman and sophomore students as well as postgraduate students (residents).

The results of these efforts will be supplied in next year's annual report.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report believing this to be an important work in each of the medical schools in the State, and suggested that thought should be given to publishing in pamphlet form the valuable material contained in the course.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EDUCATION LIAISON

Milton R. Weed, MD, *Chairman*

The Education Liaison Committee, which is one of four standing committees of The MSMS Council, has met twice this past year with two subcommittees also working on special assignments.

The work of the Committee can be divided into five areas:

1. *Ongoing efforts to improve liaison between MSMS and the three medical colleges:* The deans and/or their representatives participated regularly in Committee meetings and studies.

2. *Continuing study of the possibilities of training "physician assistants" in Michigan:* A special subcommittee, with H. J. Meier, MD, as chairman, has conducted an extensive investigation of the 1965 House of Delegates Resolution 20 to consider the development and use of "physician assistants." During 1965-66, 1966-67, and now 1967-68, the special subcommittee has held hearings with representatives of the State Board of Education, the three medical schools, and several medical specialties. The committee has studied materials from the AMA, from Duke University, which has a small physician assistant training program, and from other sources. The committee has concluded that the training of such "assistant physicians" would be feasible in Michigan. The committee has not been able to reach a final decision whether a two-year training program would be possible in community colleges, or whether four years should be required at a university with perhaps a bachelor's degree in medicine given to the graduate. All agreed that upward mobility should be assured so that the person could continue on perhaps at a later date for a regular degree in medicine. At its last meeting, the parent Committee sent a recommendation to The Council "that the Education Liaison Committee be authorized to work with interested component medical societies and physicians and their local institutions of higher education to train such personnel on a pilot basis in order to further explore the feasibility of training physician assistants." The Council approved the Committee request and at least one of the subcommittee members is exploring the subject further with a state university.

Further study of the training program, of the job description, of the many ramifications of licensure, insurance, etc., will be carried on by the parent committee and subcommittees.

3. *Consideration of possible ways to obtain more interns, residents and new physicians for Michigan:* The Education Liaison Committee late in 1966-67 requested permission from The Council to appoint a special task force committee to study changing patterns of selection of internships by graduates of the two Michigan medical schools. The task force, under the chairmanship of Kenneth L. Krabbenhoft, MD, soon expanded its scope to concern itself with the closely related questions about residents and new Michigan physicians. The task force has met with representatives of the University of Michigan Institute for Social Research to develop and conduct a

survey of senior medical students, interns, residents, and new doctors entering practice in Michigan to determine motivating factors, etc. Costs of such a survey has been estimated to range from $5,000 to $7,000. Alternative ways to conduct such a study, or to finance the project, are being considered.

Related to some degree is a medical manpower study underway now in 13 southwestern Michigan counties by the Michigan Health Council with financial assistance from the Michigan Foundation for Medical and Health Education. The MHC executive director has met with the Education Liaison Committee to discuss this regional study.

4. *Consideration of Resolution 46 adopted by the 1967 MSMS House of Delegates:* The Council referred Resolution 46 to the Education Liaison Committee for implementation. The resolved portion read: "that MSMS, in concert with the faculties of the three medical schools and the SAMA chapters establish a preceptorship program throughout the state." The Committee reviewed the reports of a previous subcommittee in 1965-66 and 1966-67 to consider a similar resolution about general practice preceptorships. That subcommittee, after considerable research and study, reported to the 1967 House of Delegates that "the preceptorship approach is only one part of a possible total program" to obtain more GPs in Michigan. The current committee has discussed Resolution 46 with medical school representatives. The importance of qualified preceptors was suggested as one of the key factors in any broad preceptorships for interested medical students. The parent committee referred the matter for detailed study to the task force committee headed by Doctor Krabbenhoft. That committee includes representatives of the three dean's offices. No decision has been reached to date.

5. *Consideration of the Report of the National Advisory Commission on Health Manpower:* The Committee has studied the 53 recommendations made by this national committee. The recommendations and the AMA comments on each appeared in JAMA, February 12, 1968. The Report was discussed by an AMA official at the 1968 MSMS Conference on Health Planning in Detroit.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EMERGENCY AND DISASTER MEDICAL SERVICES

Charles P. Anderson, MD, *Chairman*

During the year, The Council changed the name of the Committee to "Committee on Emergency and Disaster Medical Services." Therefore, the scope of the Committee has been enlarged to include emergency medical services to persons injured in accidents and to other injured and ill persons who go to hospital emergency rooms.

The Committee urges all component medical societies, with the help and cooperation of the local health department, to take leadership in developing an emergency medical care plan.

Also, it is suggested that in times of disaster, civil disturbance, and other emergencies in areas located within the county society, a representative of the county society or societies involved, contact the physicians in the disaster or emergency area to offer the help of the county society and its members. This call should be made before a request for help comes from the disaster or emergency area.

The Committee feels that H.B. 3946, licensing of ambulance attendants, now a Michigan law, will contribute greatly to the safety of patients being transported to hospitals. The Committee urges all members to give their full support to the implementation of this law and to cooperate in any way possible with the training of the personnel involved.

The Committee will endeavor to keep the membership informed via the publication of articles, news notes, etc., in *Michigan Medicine* and other MSMS publications.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EYE CARE

Robert T. Blackhurst, MD, *Chairman*

The Committee continued its liaison, in an advisory capacity, with the Michigan Department of Public Health, Bureau of Maternal and Child Health and with the Michigan Department of Social Services, Services for the Blind Division.

A postal card survey, seeking information on blind-deaf children in Michigan, was sent to all physicians and osteopaths in Michigan. This information will help to bring educational aid to these blind-deaf children and to their families, through the services of the Michigan School for the Blind.

A subcommittee is working on revisions to the State's Blind aid form; and reports were presented and discussions held on the school and preschool vision screening programs, color testing, aid to children under the Medical Eye Care Program, the identification of blind and deaf-blind infants, and the follow-up of visual referrals. The Flash Card Vision Test was demonstrated for the Committee and it was recommended that the MDPH proceed with this testing.

A report of attempts being made to identify dyslexic children and further educate them was discussed by the Committee. The pilot project in the Lansing school area is attempting to identify those children with essential dyslexia, apart from all other children. This subject will be reviewed at future meetings of the committee.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON INTERNATIONAL HEALTH

Hira E. Branch, MD, *Chairman*

One of the main efforts of the International Health Committee during the past year was to publicize the need for more medical aid to the civilian population of South Vietnam.

Doctors who had been to South Vietnam appeared on radio and television shows, urging that the United States government make a larger commitment of medical aid to South Vietnamese civilians and informing the public of the American Medical Association's Volunteer Physicians for Vietnam program.

Alfred Swanson, MD, of Grand Rapids appeared before several government groups urging an increase of medical aid to South Vietnam.

Various newspapers around the state carried feature articles and editorials on this subject. Throughout the year *Michigan Medicine* carried news articles, pictures, and editorials urging physicians to consider giving their time for work in South Vietnam. In addition, a long feature article, detailing the experience of Michigan physicians in South Vietnam, along with a special cover appeared in the February, 1968 issue of this publication.

During the period July 1, 1965 to June 30, 1968, eighteen Michigan doctors served in the Volunteer Physicians for Vietnam program.

Throughout the year, the Committee has furnished information to interested physicians about the various organizations which sponsor medical work overseas.

At present the Committee is studying the possibility of holding a one-day workshop, in cooperation with the MSU Extension Service, for physicians and lay groups on international problems of food and population.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

Harvey C. Hansen, MD, *Chairman*

The Chairman wrote to the Wayne County Medical Society suggesting that, because a joint code of understanding failed to materialize at the State level, liaison between WCMS and the Metropolitan Detroit Pharmaceutical Association might be advisable and mutually advantageous.

Resolution 7 of the 1966 House of Delegates and Resolution 10 of the 1967 House of Delegates involving Rule 16 of the Michigan Board of Pharmacy were reviewed. Further study and analysis is required before recommendations can be made. Also discussed was Resolution 50 of the 1966 House of Delegates concerned with improving the method of uniform drug identification, but no action was taken.

Discussed were the use of charcoal in Poison Antidote Kits, ethics of pre-printed prescription blanks, MSPA attempts to gain representation on Board of Michigan Association for Regional Medical Programs, drug control, prevention of refilling same prescriptions by several pharmacies, nurses' liabilities and responsibilities when telephoning orders, and the need for liaison to resolve mutual problems when they arise.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH PODIATRY

Wm. H. Blodgett, MD, *Chairman*

Pursuant to Council direction, the Liaison Committee with the Michigan Podiatry (Chiropody) Association has been engaged during the past year in dialog with leading elected officials of that organization, for the purpose of improving the understanding of physicians of the training, practice and goals of podiatry and the understanding of podiatrists of the policies of medicine concerning paramedical practice privileges in hospitals.

This constitutes an interim report, inasmuch as extensive study is going forward, on the status of podiatry around the United Sates both educationally and with regard to state laws. Considerable material has also been received from the American Medical Association and from the Joint Commission on Accreditation of Hospitals which will be carefully evaluated. Following this additional meetings with Michigan Podiatry officials will be required before a final report can be developed.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended acceptance as an interim report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH RESIDENTS, INTERNS, AND SENIOR MEDICAL STUDENTS

Norman D. Henderson, MD, *Chairman*

The Committee, after work with Merck, Sharp and Dohme, has finished plans for an educational conference on Office Management for residents, interns and senior medical students on the afternoon of September 26 at the Sheraton-Cadillac Hotel in Detroit, during the MSMS Annual Session.

Various topics for the conference were considered, and the Committee decided that the program should focus on basic principles of office management. Members of the Committee felt that the conference would be very beneficial to the young physician who is setting up practice so that his office can be both efficient and flexible enough to grow with his practice.

Conference topics were narrowed to four: a) opening an office; b) selecting personnel; c) billing system; d) evaluating partnership prospects.

The Committee is grateful to Merck, Sharp and Dohme for support of this conference and feels that this unique event will not only be of educational benefit to the young or prospective physician but will serve as an effective way of introducing him to the activities of the Michigan State Medical Society.

The Council has delegated to this Committee the authority for implementation of Resolution 54 of the 1967 House of Delegates, which deals with MSMS liaison with students of the health care professions. This matter is being studied and recommendations shall be made as soon as the Committee completes its work.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

Orlen J. Johnson, MD, *Chairman*

Revision of Statement of Principles for Lawyers and Physicians. This Committee and the State Bar Medico-Legal Committee have recommended revision of the House of Delegates, which deals with MSMS Liaison present agreement between MSMS and the State Bar. These revisions place the responsibility on the attorney to pay the physician a reasonable fee for services rendered in cases where the physician aided in preparing a case, but did not have the opportunity to testify. These changes have been approved by The Council and are now being considered by the State Bar Commissioners.

Resolution 14, 1967 House of Delegates. This resolution, concerning the feasibility of establishing a commission to study the problem of increasing malpractice suits against physicians, has been favorably considered by both committees. Representatives from both professions will soon be appointed so that this important study can be underway.

Resolution 58, 1967 House of Delegates. This resolution, aimed at clarifying Michigan law to safeguard the privileged character of medical records, is under active study by both committees. A report will be made to The Council as soon as this study is completed.

Better Communication Between the Two Professions. A plan to improve communication between the two professions by establishing liaison representatives on a geographic district basis is being developed. A full report will be made to The Council as soon as this work is completed.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON WITH STATE BOARD OF REGISTRATION IN MEDICINE

K. H. Johnson, MD, *Chairman*

The Committee met with the members of the State Board and representatives of the Investigations Division, Department of Licensing and Regulation. Items discussed were training of investigators, limitations of Medical Practice Act, responsibilities of office personnel performing delegated services and the use and abuse of narcotics.

MSMS has asked the State Board to annually publish a list of those licensed to practice in Michigan by county with a copy to each county clerk.

MSMS also urged the State Board to study and implement, if possible, the following recommendation:

> "The State Board be expanded to include a group of physicians, qualified in drug dependency, to serve in an advisory capacity to law enforcement agencies in any kind of problem that would have to do with misuse and improper dispensing of drugs by physicians."

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE EXECUTIVE OFFICE

KENNETH H. JOHNSON, MD, *Chairman*

One of the most vital correlated activities of the "governmental relations" section of the MSMS Headquarters office is the maintenance of close and effective liaison with the Office of the Governor of Michigan, including not only the Chief Executive himself but also his chief staff aides concerned with legal, agency and program matters. Policies of MSMS are enunciated to the Executive branch of Michigan State Government through the activities of this liaison committee, which also assists upon request with appointments to councils and advisory bodies. Appropriate contacts are also made with the Lieutenant Governor and his staff.

It is more the rule than the exception that the Executive Office will consult the MSMS Liaison Committee on such matters of great importance to medicine as formation of the State Health Facilities Council, Comprehensive Health Planning Advisory Committee, and similar bodies. As an example of the importance of matters discussed by this Committee and the Executive Office, the study of a possible merger of the Public Health and Social Services Departments is cited. The Committee acts only upon directive of The Council.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS

JAMES S. FEURIG, MD, *Chairman*

The Committee's major activity this year was the presentation of the Third Annual Michigan Conference on the Medical Aspects of High School Sports at Detroit, May 8, 1968. The Committee organized the fine program and secured the cosponsorship of the University Center for Adult Education (a cooperative adult-education project of Wayne State University, the University of Michigan and Eastern Michigan University) to obtain use of the Rackham Center in Detroit.

One hundred team physicians, coaches, trainers and high school principals participated in the program. Speakers included team physicians for the Notre Dame Irish and the Ohio State Buckeyes, and an official from the dental service division of the Michigan Department of Public Health.

The Committee, with the approval of The Council, is now actively urging component medical societies to help high schools in their area to obtain doctors of medicine to serve as team physicians.

Three committee members spoke at the annual meeting of the Michigan Association of physical education.

The Committee cooperated with the Committee on Child Welfare in its development of a position statement about high school wrestling weights for the State Departments of Education and Public Health.

The 1968 MSMS Awards Luncheon in Detroit February 24 included "Outstanding Health Service Awards" to Charles Forsythe, executive director of the Michigan High School Athletic Association, and to two members of the Committee, Chairman James S. Feurig, MD, East Lansing, and Gerald A. O'Connor, MD, Ann Arbor.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND RELIGION

WINSLOW G. FOX, MD, *Chairman*

The moral and ethical issues facing physicians today were discussed at MSMS headquarters by 30 chairmen of county medical society medicine and religion committees and other invited guests, in a day-long workshop.

The Reverend Doctor Paul B. McCleave, Director of the AMA Department of Medicine and Religion participated in the Workshop. Luncheon speaker was LeRoy Augenstein, Ph.D. — his topic: "Who Shall Decide?"

The Committee on Medicine and Religiou co-sponsored with Alma College a physician-clergy workshop on May 2, 1968. Keynote speaker was Reverend Robert E. Reeves, Jr., Chaplain of Columbia Presbyterian Medical Center, New York City.

During the past year over 35 county medical societies participated in medicine and religious activities. The Committee hopes that every county society will name a chairman and activate a committee in 1969. This Committee's purpose is to develop a program to create a stimulating climate for communication between physicians and clergymen, leading to more effective care and treatment of the patient.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MICHIGAN MEDICAL HISTORY

JOHN R. G. GOSLING, MD, *Chairman*

During the past year the Committee has continued its interest in Michigan's medical history in the following ways:

The Committee recommended (and The Council approved the recommendation) that a repository be determined for objects, literature, photographs, etc., of an historical nature. Accordingly, space has been made available at MSMS Headquarters for such a repository.

Through Alfred H. Whittaker, MD, the Committee has contacted the Michigan Historical Society and proposed that it establish a medical history branch. Work on this project is continuing.

The Committee has also investigated the possibility of distributing the Stapleton book on medical history during the Wayne State University Medical School's centennial celebration and at various medical meetings. Work on this project is also continuing.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON NURSING

Robert L. Tupper, MD, *Chairman*

During the past year the Committee has been concerned with various questions of nurse practice. After much deliberation the Committee decided that its role in answering many of these questions is to serve as a clearinghouse for the questions, referring them to the appropriate medical and nursing specialty groups for their recommendations. The Committee does, however, recommend that guidelines for nursing practice be established.

The Committee has also been interested in various legislative issues, specifically the proposed rules and regulations to the Nurse Practice Act of 1967.

In October 1967 the Committee Chairman attended the AMA-sponsored Conference on Nursing in Chicago. One of the charges there was for each state Committee to attempt to develop dialogues similar to the three previous ones conducted nationally between physicians and nurses. Partially as a result of this and partially by independent impetus from the liaison group from the Michigan Nurses Association, a significant effort to this end was developed.

Accordingly, the major work of the Committee during the past year has been to plan and sponsor an MD-RN dialogue-type conference, September 4-5, 1968, at the MEA Conference Center, St. Mary's Lake. Outstanding speakers should fulfill the three main objectives of the Conference: 1) to serve as a pilot venture for future local and state level conferences to improve physician-nurse working relationships; 2) to improve the physician-nurse working relationships and understanding in actual practice; and 3) to improve patient care as a result of better cooperation between physicians and nurses. The Committee is grateful to MSMS and the MNA for their financial support of the Conference.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON REHABILITATION

Richard W. Pomeroy, MD, *Chairman*

1967 House of Delegates Referrals. The Committee considered Resolution 22 entitled "Study of Adequacy of Training of Certain Paramedical Personnel."

During the year, the Committee studied the "Proposed Guidelines for Physician Therapy Aide Training" as printed and approved by the American Physical Therapy Association. The "Guidelines" are essentially an outline of subject matter which could be included in an aide training program. The "Proposed Program for Physical Therapy Aide Training," a sample of the way that an aide training program might be organized, also was reviewed by the Committee. Guidelines and program for the training of assistants have not as yet been approved by the APTA.

The Committee does not see how it can make the study as indicated in the resolution, but feels it is in a good position to review any new programs for the teaching and training of paramedical personnel in the State and will keep The Council informed.

In reviewing Resolution 23, "Recognition of the Board of Registration of Physical Therapists," the Committee informed The Council that there is only one body of registered physical therapists, with no other level of physical therapists being recognized at this time. The Michigan law definitely sets forth the qualifications of a physical therapist.

The Committee sent an explanatory letter and a copy of the Michigan law to the secretaries of Michigan's component societies on August 31, 1967.

The recommendation contained in the *Annual Report of the Liaison Committee with the Michigan Crippled Children Commission and Resolution 25,* concerned with the care of handicapped children, were reviewed by the Committee.

The Committee will cooperate in all ways possible with the Committee for the Care of the Handicapped Child of the American Academy of Orthopaedic Surgeons and will maintain liaison with other organizations, agencies and departments involved in the care of handicapped children in Michigan.

Rehabilitation Nursing. The Committee asked The Council to make known to the Michigan Association for Regional Medical Programs its concern that there is a real need for nurses to be trained in the rehabilitation aspects of heart disease, cancer and stroke, and to urge MARMP to set up a program in the immediate future to insure an adequate number of trained rehabilitation nurses to care for patients suffering from heart disease, cancer, stroke and related diseases.

MARMP replied that a Rehabilitation Nursing Program was being developed at Wayne State University and University of Michigan and that other programs were under consideration, and that the recommendation would be shared with the appropriate corporation committees, the three universities and the Michigan Department of Public Health.

Rehabilitation Nursing Careers. The Committee is cooperating with the Michigan Health Council in setting up an exhibit for the Career Mobile and working on the possibility of moving beyond the exhibit and attempting to make some personal contacts with the students in the schools. The Committee feels it important to get the personal involvement of students interested in rehabilitation nursing, after the initial exposure to the exhibit.

Visit to Traverse City. The Committee visited the rehabilitation facilities at Munson Hospital in Traverse City and plans to visit other such facilities throughout the State.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

RELATIVE VALUE STUDY COMMITTEE

Ben R. VanZwalenburg, MD, *Chairman*

The Committee, by a meeting on April 6 and by intracommittee correspondence has carried on its assigned task of studying the Michigan RVS.

The finalized AMA current Procedural Terminology (CPT) has not been published. This precludes any attempt to resolve the differences between the CPT and the Michigan RVS. We expect that the CPT will eventually be adopted nation-wide and that the Michigan RVS should be brought into line with the CPT nomenclature and numbering system.

The need for continuing the Michigan RVS was discussed. It is obvious that the "variable fee" type of payment by third parties will more accurately reflect current charges and their variations by location and by specialty than does an RVS. The Committee, however, feels that the Michigan RVS should be continued as it is a valuable reference for physicians and third parties.

The continuing necessity for annual revision of the Michigan RVS is indicated because fee patterns are constantly changing in response to developments in medical science and practice.

The Committee recommends approval of the *1965 Michigan Relative Value Study,* (revised 1968) to mirror current relative values. The 1968 revisions include minor changes in Neurosurgery, major changes in Anesthesiology and changes in Radiology, Radiotherapy-Radionuclides. (It is expected that the changes in Radiology nomenclature will be largely followed in the new CPT).

Errors in last year's RVS were corrected by omission of procedure 9606 and correction of procedures 9359 and 9363.

The Committee expresses its thanks to the representatives of the Michigan Association of Neurological Surgeons, the Michigan Society of Anesthesiology and the Detroit Roentgen Ray Society for their assistance. The Committee also expresses appreciation to Richard Campau and his office for carrying out the involved staff duties inherent in preparation of this year's revisions.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the RVS, revised 1968.

THE HOUSE adopted the report of the Reference Committee.

18. Annual Summaries of Standing Committees

ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Glenn E. Millard, MD, *Chairman*

There have been no formal meetings of the Committee during the past year, although many of the advisors have attended meetings of the Medical Assistants Society, and the advisors have been asked for their counsel and advice.

The Committee has been very much interested in the education and certification programs of MSMAS and has encouraged the expansion of these programs. The MSMAS Education Committee is constantly striving to increase the number of formal training centers in Michigan and to insure the excellence of the training they provide. In addition, MSMAS has sponsored two educational seminars for its members as well as an officers' training conference during this past year. Eight MSMAS members are now Certified Medical Assistants, indicating that they have passed examinations requiring great competency in clinical and administrative fields. The Committee encourages MSMAS members to prepare for and take the certification exams.

MSMAS has undertaken several public relations projects this year. The AMA publication "Winning Ways with Patients" has been distributed to over seven thousand physicians' offices throughout Michigan. MSMAS officers and the Committee Chairman have written articles published in *Michigan Medicine*, and special medical assistants meetings and programs have been publicized in the news media.

Despite a growing membership in MSMAS, the Advisory Committee continues to be concerned about the number of members. The Committee urges MSMS members to encourage their medical assistants to join MSMAS.

Further information about the activities of MSMAS during the year are given in the President's report to the House of Delegates and her written report in the Delegates' Notebook.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Edward H. Rodda, MD, *Chairman*

Since no problems of policy relative to the Auxiliary arose during the past year, it was not necessary to call a formal meeting of the Advisory Committee. However, all members of the Committee were readily available for advice and counsel.

The Advisory Committee urges all MSMS members to encourage their wives to join the Auxiliary and help advance its work. Although membership has increased during the past year, the Advisory Committee would like to see the potential membership realized.

The Auxiliary has undertaken and completed many valuable projects during this year, many of which are reflected in the President's report to the House of Delegates and in her written report in the Delegates' Notebook.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AGING

A. Hazen Price, MD, *Chairman*

The Committee on Aging has held two meetings with excellent attendance of its membership. Of major committee interest were (1) aspects of nursing home care, (2) the progress of MARMP, and (3) the extent of inclusion of concepts of preventive medicine in the curriculum of medical schools. An area conference on rehabilitation and long term care of elderly patients was held at the Saginaw County Hospital, with the Committee on Aging as cosponsor.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended that this very important committee offer direction to the members of MSMS and that it encourage further liaison with the AMA Committee on Aging.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON BLOOD BANKS

Lawrence W. Gardner, MD, *Chairman*

Having secured The Council's support on May 9, 1967 — "approved study by the Committee on Blood Banks regarding the possible establishment of a central (viral hepatitis) registry, the study to include methods of financing and legal responsibilities of providing information concerning donors," probing actions have been made to the Red Cross and Michigan Department of Health. Both organizations have expressed sincere interest in this endeavor and are in the process of formulating specific recommendations to our Committee.

Relative to the Red Cross: American Red Cross at the national level does not object to such a registry and have made computer space available to the Southeastern Michigan Chapter for this purpose on a community wide basis, if the community desires to participate. However, a definite proposal has not been rendered.

Relative to the Michigan Department of Health: An application for a contract has been sent to the National Heart Institute for financial support to determine the feasibility of a serum hepatitis registry. This study would include actual trials of a proposed system. The type of system, mode of operation, method of financing, effectiveness, etc., are points requiring considerable investigation.

These organizations and our Committee feel that a statewide system of reporting to blood banks those persons having had hepatitis or having been implicated in a transfusion causing hepatitis will be valuable. At the present time, such a system for controlling viral hepatitis has not been formulated in any state. We trust the House of Delegates appreciates the tremendous complications of this endeavor.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CANCER

Max E. Dodds, MD, *Chairman*

The Committee discussed how the MSMS and its members could participate in an educational program on smoking and health. Discussions were held with a representative of the Michigan Council on Smoking and Health and the MSMS Public Relations Committee, and a subcommittee was appointed to meet with other scientific committees to subsequently present recommendations to The Council for such a program.

The Committee feels that MSMS should become meaningfully involved in and influence projects developed by universities and others in connection with the programs of the Michigan Association for Regional Medical Programs. The Committee recommended to this organization that it consider at pilot program of two-way radio conference programs and the establishment of a training course for teaching of uniform tumor registry procedures for local hospital personnel. MARMP replied that the recommendations would be shared with the appropriate corporation committees and with the three universities along with the Michigan Department of Public Health and the Michigan Cancer Foundation.

The Committee expressed its view that all hospitals in Michigan should have approved cancer programs with trained personnel. A survey of the status of cancer registry techniques in Michigan will be made by the Committee.

In addition, the Committee will look into the Muskegon video educational to see if there is a way this type of program can be extended to cancer education in Michigan, through the cooperation and help of the Committee.

The Committee feels that, although health and cancer quackery exists in Michigan, the problem does not seem to be too great.

Two members of the Committee continue to serve as representatives to the Michigan Cancer Coordinating Committee with routine reports to The Council. The MCCC continues to coordinate cancer efforts in Michigan and supplies cancer speakers for meetings of physicians, dentists, and osteopaths.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, was impressed with the Committee's activities and recommended acceptance of the report with minor editorial changes.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CARDIAC DISEASE CONTROL

Sidney E. Chapin, MD, *Chairman*

Rheumatic Fever. Cooperation has continued with the Michigan Heart Association's Rheumatic Fever Committee and the Committee has helped with the statewide rheumatic fever conferences. Discussions were held with the MHA rheumatic fever coordinator. The Committee will continue to evaluate 1. the value and use of throat cultures; 2. the need for community programs; 3. the "injudicious" use of antibiotics; 4. problems of people with fixed valvular heart disease; 5. the unavailability of adequate laboratory service in some communities; 6. the possibility of circulating laboratory service, with the help of local health departments; and, 7. the use of "do-it-yourself" throat culture kits.

The Committee has offered its help to the Michigan Department of Public Health in its current study of bicillin program.

Nutrition Survey. The MHA Nutrition Survey has resulted in 1,914 responses. When the coding is completed and the report written, the Committee will review the results.

Michigan Association for Regional Medical Programs. The Committee met with A. E. Heustis, MD, Executive Director of MARMP, and recommended that, because The Council of MSMS can, and does, disseminate information to individual physicians, it launch a program to acquaint the "grass roots" physicians, statewide with the aims and program of MARMP.

The Council approved this recommendation and in addition, requested Doctor Heustis to prepare an article for publication in *Michigan Medicine* in August or September, 1968.

Screening Program. The Committee reviewed the action taken by the 1967 House of Delegates regarding screening programs.

Guide for the Registered Nurses in a Cardiac Care Unit. The Guide has been reviewed and approved by the Committee.

Liaison. The Committee will continue its liaison with MHA and other persons and groups concerned with cardiac disease control.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CHILD WELFARE

John M. Dorsey, Jr., MD, *Chairman*

The minutes of the Committee's meeting will not be considered by The Council until the time of the 1968 Annual Session.

The Committee is recommending that The Council request the Michigan Department of Social Services to consider changing its rules regarding summer camp physician examination and immunization requirements to fit in with the Committee's recommendation of May, 1967: "(1) That if a physical examination has been given the child within a period of six months; (2) That if the child's immunizations are current; and (3) That if a child has not been exposed to recent communicable diseases, such examination of six months duration be considered adequate to cover the requirement of a physical examination prior to entering summer camp. This examination is not to exclude the health inspection given on the day the child enters the camp."

Due to increasing requirements and needs for better and closer liaison between physicians and schools and school board personnel, the Committee is recommending that The Council recommend to component societies that attempts be made to develop better local school health liaison; also, that The Council make known to the Michigan State Board of Education this interest on the part of physicians in Michigan with the suggestion that the State Board in turn recommend to all local school boards that a contact be made with the local county medical society, requesting the appointment of medical consultant(s) to the local school board.

A committee has been appointed to work with interested personnel from medicine, education and related fields, to study the problems and experiences in the Midland area with the use of the Wetzel screening system and to report back to the Committee. The Wetzel screening system in the Midland area in 1967 found that the average growth failure was 16 per 1,000 children examined.

The Committee has recommended that The Council take special note of the pre-pilot project being done in the Lansing schools to ascertain the number of dyslexia children and what can be done to help them. At the proper time, the Committee will publish in *Michigan Medicine* information regarding the dyslexia project and resulting recommendations.

Also considered by the Committee was Resolution 14 of the 1965 House of Delegates and the referral of the Resolution to it by the Liaison Committee with the Michigan State Pharmaceutical Association. Objection had been heard about the continuing use of charcoal as contained in the Poison Antidote Kit despite the fact that articles had been published recommending its use in certain instances of accidental poisoning.

The Committee is recommending to The Council that it approve the Committee's statement recommending the use of the Poison Antidote Kit, as sponsored by the Michigan State Pharmaceutical Association. In order to provide uniformity across the country, and to avoid conflict with the recommendations of the American Association of Poison Control Centers, the Committee feels that the charcoal contents of the kit, when used in accordance with proper instructions, constitute no extra hazard.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DIABETES

William M. LeFevre, MD, *Chairman*

Since no matters were brought to the Committee during the past year, no meetings were held.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with the suggestion that the Committee explore the feasibility of closer liaison with the Medical Advisory Committee of the Michigan Diabetic Association.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON GOVERNMENTAL MEDICAL CARE PROGRAMS

Paul T. Lahti, MD, *Chairman*

The Committee was supplied with pertinent information by representatives of the Michigan Association for Regional Medical Programs, Michigan Department of Public Health and the Michigan Office of Economic Opportunity so that now the Committee can be of greater assistance in recommending appropriate MSMS coordination and cooperation. The Council adopted a recommendation that component medical society members be more active in every health planning organization concerned with medical care and its distribution. A list of organizations representing or involved with hospitals currently working in a socioeconomic field was prepared and distributed to all officers of component medical societies.

The Committee reviewed the 1967 amendments to the Social Security Act and is studying the Report of the National Advisory Commission on Health Manpower.

As a result of the Chairman's attendance at the National Conference on Health Care, the Committee was authorized to and did communicate with all federal/state agencies in Michigan involved in health care for the poor to offer to provide medical advice and consultative services. A recommendation to hold a statewide conference on health care for the poor as a part of the next MSMS Scientific Session was referred to the Ad Hoc Committee to Study the Medical Problems of the Disadvantaged in Cities.

The Committee continued its concern for physicians' reimbursement by all governmental agencies. The Council accepted a recommendation that "In the future, payments from all governmental agencies be on the same basis (the usual, customary and reasonable fee) as Title 18B-Medicare and that this recommendation be forwarded to all county medical societies for use in negotiating with local governmental agencies."

Attention was also devoted to matters related to extended care facilities, such as death certificates, stocking of emergency drugs, reports of radiologists' and physicians' visits, and length of stay.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended acceptance of the report commending the Committee for its diligent efforts.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HIGHWAY INJURY

Paul W. Gikas, MD, *Chairman*

The Committee succeeded in securing approval to distribute Medi-Labels to responsible lay organizations as well as to physicians.

By request of the Secretary of State, the Committee was uniquely privileged to review the manner in which the Department evaluates medical statements as they relate to driver licensing, as well as the procedures used, to initiate a request for medical opinions. Informal meetings and liaison preceded the on-the-spot review and a critique was transmitted to the Department making appropriate suggestions for improved methodology.

The Committee continued its quest to upgrade the emergency medical transportation system. Discussions were held with appropriate state legislators and Department personnel offering strong support for the establishment of minimum standards for ambulances, ambulance drivers-attendants. Members testified before three special committee hearings and maintained continuous liaison.

The Committee was invited to recommend nominees for Executive appointments and handled a number of requests for information and assistance.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON IODIZED SALT

Brock E. Brush, MD, *Chairman*

During the past year, several attempts have been made to select a meeting date convenient to most of the members of the Committee and to the three representatives from The Council. A meeting was scheduled with five Committee members and two of the Council's representatives indicating they would be present. Those present felt it important to discuss the future program and purposes of the Committee and to make recommendations that might be considered by the 1968 House of Delegates.

The Committee recommended to The Council that the Michigan State Medical Society renew its efforts and take active leadership with material interest in the support of the education of the public and of the physicians in the State of Michigan to stress the need for using iodized salt to prevent endemic goiter, which, according to the studies of William H. Beierwaltes, MD, and his associates, of Ann Arbor, is a continuing and rising problem among the citizens of the State of Michigan.

At its meeting in June, The Council discussed the possibilities of: 1. including goiter under the Public Health Committee, and 2. the possibilities of MSMS legislative efforts to make iodized salt mandatory under state law. The Council agreed that both possible approaches should be explored further with the Committees on Public Health and on Legal Affairs.

Therefore, the future of the Committee on iodized salt rests with the recommendations resulting from a future joint meeting of the Committee on Iodized Salt, the Committee on Public Health, and the Committee on Legal Affairs. Our Committee would like to move ahead on these problems and do a more effective job. We are not satisfied with our progress of the past few years.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended approval of the report and encouraged favorable joint action by the Committees on Public Health and Legal

Affairs in the proposal to secure legislative action to insure continued success in this public health measure.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON LEGAL AFFAIRS

Otto K. Engelke, MD, *Chairman*

An extremely arduous year of legislative activity was completed on June 26, 1968 with the adjournment of the Michigan State Legislature. During six months of intensive activity the lawmakers in Lansing considered hundreds of health-related proposals, some of them of great significance to all practicing physicians. At the close of the session not one new law had been added to the Michigan Statutes which had been vigorously opposed by MSMS; on the other hand, the Society had strongly supported passage of fully as many bills as it had felt it necessary to oppose or seek to amend, and a large number of MSMS-endorsed bills were adopted to the benefit of the profession and the people of Michigan.

The Legal Affairs Committee commences to prepare for a legislative session immediately following each meeting of the House of Delegates. It has met on more than one occasion before the Legislature gathers in the State Capitol and it meets again several times during the session proper. In this past year activities have been thoroughly reported to the total MSMS membership through a half-dozen "Medigrams," special letters when required in emergencies, and many pages of articles in the centerfold of *Michigan Medicine*. A complete recapitulation of bills of interest was mailed to all members on June 4, at which time a new service was instituted making available to any physician who requested them copies of any newly enacted laws of particular interest to him.

It must be strongly emphasized that the success of MSMS' legislative effort is always due in large measure to the splendid response of the profession when it is called upon to speak to individual legislators about important proposals. MSMS members, during 1968, have been particularly alert and cooperative, and the State Legislature by and large has been courteously receptive to MSMS views. Much hard work must be done by those who are "on the firing line" every day, and many individual physicians have given generously of their time and expertise to come to Lansing to actually testify before committees. The fact, however, that increasingly physicians are taking an active interest in government, getting to know their own lawmakers, and expressing themselves regularly has strengthened a key ingredient in our legislative activity. The Committee wishes it could personally thank every member who has assisted during this past year.

Finally, the Committee would point out that a new State Legislature will be elected a little over a month after the 1968 House of Delegates meeting. Being so intimately associated with the importance of volume of legislative activity, the Committee would most strongly urge every physician, as an individual citizen, to evaluate the political candidates in his community and support, in any way possible, those whom he considers best qualified to make the laws of our State.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the report congratulating the Committee for an excellent job.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MATERNAL HEALTH

James E. Harryman, MD, *Chairman*

The Central Maternal Mortality Review Subcommittee has continued its review of maternal deaths in Michigan and has been greatly aided by the large percentage of autopsies performed.

The Perinatal Morbidity and Mortality Subcommittee has distributed three Perinatal Newsletters during the past year, and has provided information and help to Michigan hospitals wishing to participate in the Michigan Perinatal Mortality Study.

The Lay Education Subcommittee served as the motivating force in the successful adoption of legislation to permit the teaching of family life and sex education in Michigan's schools. The Committee will continue to serve in an advisory capacity to the Michigan Department of Education, and to other groups involved in setting up the curriculum for the teaching of family life and sex education. In addition, the Committee plans a Family Life Education Workshop for representatives of component societies next October.

The Medical Liaison Committee continues its publication of Desk Reference Cards and has received the approval of The Council to reprint all 10 cards in a future issue of *Michigan Medicine* and to print future cards in this manner.

The Maternal Mortality Tissue Registry Subcommittee hopes that it will be possible to have a complete report assembled by the end of 1968. The report will include study sets of significant pathology with Kodachrome slides and text. The year 1968 marks the Tenth Anniversary of the Registry.

The Annual Maternal Health Conference Subcommittee held another very successful Maternal Health Conference in Flint in March. The Annual Report of The Council contains a report on this meeting. The Committee is grateful to the Clara Elizabeth Fund of Flint for its continued interest and tangible help in co-sponsoring the Flint Maternal Health Conferences.

The Committee continues its cooperation with the Michigan Department of Public Health, Bureau of Maternal and Child Health, in efforts toward better utilization of obstetrical hospital beds.

Other matters discussed by the Committee during the past year: Michigan perinatal and infant mortalities; prematures and what kills them; RH immunoglobulin; training in obstetrical care and delivery for all physicians accepting patients for such care; the bringing together of physicians, hospital board members and hospital administration to discuss the combined responsibility of obstetrical care; the need for more hospital perinatal study officers and review committees; the training of more nurses for obstetrical care; and Michigan's abortion laws and other legislation of concern to the Committee.

The Committee expressed appreciation to William W. Jack, MD, for his good work as Chairman of the Committee for many years, and sadness and great loss in the death of Arthur C. Rutzen, MD, a long-time member of the Committee and the newly appointed Chairman at the time of his death.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended approval of the report with highest commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

Dale L. Kessler, MD, *Chairman*

Long Range Planning Project. The following position papers have been received and published in *Michigan Medicine:*

1. "The Future of Health Insurance, Prepayment and Medicine — A View of 1985," by Charles P. Hall, Jr., Ph.D.
2. "The Outlook for Group Practice — Prepayment Direct Service Plans During the Next 20 Years," by Caldwell B. Esselstyn, MD.

3. "The Medical Profession and the Public: An Examination of Interrelationships," by Odin W. Anderson, Ph.D.

Additional papers have been received or are under contract and will be published within the next several months. They are:

1. "The Future of Private Practice: Salvation at the Grassroots," by Lewis A. Miller
2. "Medical Facilities and Medical Practice 1985," by Ray E. Brown.
3. "The Influence of Government Fiscal Agents on the Future Practice of Medicine," by Thomas B. Fitzpatrick.

After all the papers have been published in *Michigan Medicine,* reprints will be sent to each state medical society. It is hoped that this will result in the development of new approaches and programs by organized medicine to meet the challenges that medicine will face. Also, the Committee will conduct workshops around the state to focus the attention of component medical societies on the future.

The Committee is pleased to report that Charles Hall's paper on "The Future of Health Insurance and Prepayment" was selected by a jury representing the American Medical Association, the American Medical Writers Association and the National Association of Blue Shield Plans as the most scholarly contribution to the literature of medical economics for the year ending June 30, 1967. Doctor Hall was presented the Norman A. Welch MD Award by the N.A.B.S.P. for his achievement.

Survey of Fees in Wayne County. Upon the recommendation of the Committee, The Council approved a request from the Wayne County Medical Society that the Committee conduct a survey of fees by specialty and type of practice in Wayne County. This survey is underway. The results should be of significant value to physicians, not only in Wayne County, but throughout Michigan.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND OSTEOPATHY

John J. Coury, MD, *Chairman*

This Committee again had a busy year in its attempts to formulate policies that would resolve the problem of Medicine and Osteopathy.

Our major efforts concerned 1) the development of a proposed single medical practice act for Michigan and 2) obtaining changes in the policies of AMA that would permit qualified osteopaths to participate in AMA-approved internship and residency programs.

The Committee worked closely with the MSMS Committee on Legal Affairs and MSMS Legal Counsel in drafting a new medical practice act that would place both MDs and DOs under one licensing board. The details will be presented to the House of Delegates in a separate report.

Resolution 60 (Acceptance of Osteopaths as Residents and Interns) of the 1967 MSMS House of Delegates was presented at the June meeting of the AMA. Although the resolution was not adopted, it will be considered by the AMA Council on Medical Education, which is studying this entire matter.

This concept is condemned by the American Osteopathic Association, but it has engendered a great deal of interest and support by the younger practicing osteopaths.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report, commending the committee for its farsightedness and sincere efforts in resolving one of the most difficult problems of the times.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MENTAL HEALTH

Benjamin Jeffries, MD, *Chairman*

The Committee appointed a representative to a special state legislative committee to study admissions, commitment procedures, and reimbursement rates for mentally ill children, adolescents and adults. Reviewed were the problems of drug purchases for indigents, abortions, and the Department of Mental Health's activities in Act 54 programs (Community Mental Health Service).

The Committee discussed the Psychologists Registration Act, heard a progress report on the new Forensic Center, and recommended its completion before the Department implements a proposal for joint facilities with the Department of Corrections. A report was given that the State Legislature is attempting to repeal the sexual psychopathic law.

The Committee reiterated a previous position that the Department of Mental Health initiate a cost for service basis instead of the current billing procedure of per diem rate charges. Also discussed were the financial liabilities of relatives of committed patients, a strategem to liberalize abortions, and a joint meeting with appropriate state legislators in late 1968. The Committee voted to continue an in-depth study of Strategy for Planned Educational Change (SPEC) after hearing a report.

Other matters reviewed and discussed were the use of generic equivalent prescriptions by state agencies, the 14th Annual Conference of State Medical Society Mental Health Representatives, community psychiatric centers, the future of large mental hospitals, the continuing problems of community mental health service programs, planned workshops in community psychiatry, legislative activities in mental health, mental retardation, alcoholism and drug abuse.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON OCCUPATIONAL HEALTH

William Jend, Jr., MD, *Chairman*

During the past year the Committee on Occupational Health was involved in the following matters:

1. *Review of written materials on Workmen's Compensation.* The Committee reviewed publications from other state occupational health committees and also studied the Wisconsin Occupational Health Guide with a view to similar publications in Michigan.
2. *Survey of county societies to determine which had an occupational health committee.* The Committee found that very few county societies had such committees, and deplored this condition in a major industrial state.
3. *Consultation with the Michigan Department of Labor.* This state agency asked for the advice of MSMS in developing physical examination standards for operating engineers. Subsequently, the Committee discussed informally with department officials in Lansing possible standards to assure maximum safety for the operator and the people who are working with him. Practical considerations in implementing such standards were also discussed.
4. *Consultation with the Department of Civil Service.* This agency requested MSMS help in formulating a physical examination benefit as part of a group health plan and, as with the Department of Labor, the Committee met informally with Civil Service officials in Lansing to discuss possible ways to achieve the objectives the department has in mind.

   The Committee is currently planning a meeting with the MSMS Committee on Alcoholism and Drug Dependence to discuss the problem of alcoholism in occupational health.

Also a future meeting will be planned with the Michigan Academy of General Practice to discuss matters of common concern.

In addition, the Committee will continue to help in the development of a possible program involving pre-employment medical examinations for MSMS employees.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Harry A. Towsley, MD, *Chairman*

During the year 1967-68, the Committee on Postgraduate Medical Education of the Michigan State Medical Society provided 37 programs in continuing medical education in 20 centers distributed geographically throughout the state; 12 were in the lower peninsula and 8 in the upper peninsula.

Registrations for the spring and fall sessions totaled 1,033 physicians of which 637 attended both the fall and spring meetings. Twenty-three of the programs held were combined live clinics with didactic presentations; fourteen presentations were didactic lectures only. Thirty-nine faculty members representing Michigan State University, the University of Michigan and Wayne State medical schools participated in these programs.

The Committee on Postgraduate Medical Education is deeply indebted to those faculty members who, with dedicated services, made possible continuing education for physicians enabling members of the State Medical Society to continue their education in the medical sciences at their own doorstep.

The Committee has repeatedly expressed its conviction that the greatest value is received from programs where clinical conferences with presentation and discussion of patients' problems in the local community are available.

During the year, one new center was added to the list: Livingston County. It is noteworthy that in Howell, Michigan, their program was attended by 43 physicians. There are 21 physicians who are members of the Livingston County Medical Society. The Committee wishes to recognize the sincere efforts put forth by the members of the Livingston County Medical Society in encouraging members of other county medical societies to attend this meeting.

Following is a list of faculty members and others who contributed to the program:

Richard J. Allen, MD
Thomas A. Bruce, MD
Oswald V. Clark, MD
Ralph J. Coskey, MD
Arthur C. Curtis, MD
Thos. J. DeKornfeld, MD
Reed O. Dingman, MD
Earl R. Feringa, MD
Stuart M. Finch, MD
F. Bruce Fralick, MD
A. James French, MD
Robert H. Gregg, MD
E. Richard Harrell, MD
Ruth Heyn, MD
Roland G. Hiss, MD
Robert B. Jaffe, MD
Benjamin Juliar, MD
Richard D. Judge, MD
Robert C. Kelsch, MD
George H. Koepke, MD
Richard O. Kraft, MD
S. M. Lindenauer, MD
Paul Lowinger, MD
George H. Lowrey, MD
Kenneth R. Magee, MD
George W. Morley, MD
Reed M. Nesbit, MD
Norman D. Nigro, MD
William R. Olsen, MD
Ananda Prasad, MD
Stewart E. Pursel, MD
Richard C. Schneider, MD
Edwin M. Smith, MD
Scott N. Swisher, MD
Harry A. Towsley, MD
Neal A. Vanselow, MD
David Watson, MD
Park W. Willis III, MD
Robert Wilson, MD
Walter P. Work, MD

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

Fredrick Weissman, MD, *Chairman*

Improvements in the MSMS Group Disability Plan. Several improvements in the MSMS Group Disability Plan were worked out by the Committee and the Provident Company. These include: (a) a reduction of premium for the the lowest age group (under age 34), (b) an increase in the available maximum indemnity from $500 to $1,000 monthly, (c) an insurability guarantee provision, (d) an extension of the disability benefit period for members under age 50 from age 65 to lifetime.

Disability Insurance for Employees of MSMS Members. This new group program, as developed by the Committee and approved by The Council, went into effect on April 1, 1968. The plan is underwritten by the Provident Life and Accident Company. It provides monthly cash benefits for enrolled employees of MSMS members who become disabled because of accident or sickness. A one-year accident — one-year sickness plan or a five-year accident — two-year sickness plan is available.

Adoption of New Blue Cross and Blue Shield MVF-2 Package Program. The Council on June 5, 1968, approved this Committee's recommendation that MSMS adopt the new Blue Cross and Blue Shield MVF-2 package. This program replaces the present M-75, and Over-65, group health programs available to MSMS Members. It offers an expanded scope of benefits and becomes effective August 1, 1968.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

Oscar D. Stryker, MD, *Chairman*

Smoking and Health. The Committee heard reports from the Committee on Public Relations and from the Michigan Council on Smoking and Health and very thoroughly discussed an educational program for physicians and the public on smoking and health. Because The Council had requested that a Task Force be appointed to set forth recommendations regarding such an education program, and because the Committee on Cancer had also recommended this be done, the Committee on Public Health assumed the responsibility and leadership in setting forth a recommended program of education that can be presented to The Council and subsequently referred to the Committee on Public Relations, the Public Relations Department, and the Michigan Council on Smoking and Health.

The Committee has requested the help of the Committee on Cancer and the Committee on Respiratory Diseases, and will submit its recommended program to The Council in the near future.

Radiation. The Committee has the addition of two advisors, R. C. Hildreth, MD, and J. E. Lofstrom, MD, to serve as liaison with the Radiation Section of the Michigan Department of Public Health.

The Committee is in favor of protecting the public and physicians from the hazards of defective radiation equipment, and has recommended that in problem cases the

Radiation Section of the Michigan Department of Public Health, consult with the Committee's Advisors on radiation who in turn can contact the physician in person or notify the local county medical society of the violation and if, after a contact is made, the physician still fails to comply with the regulations, that the Department contact the local law enforcement people.

Mumps and Measles Vaccines. The Committee discussed this matter with George H. Agate, MD, Chief of the Division of Epidemiology of the Michigan Department of Public Health, and requested him to write an article for *Michigan Medicine* on the "Pros and Cons of Mumps vaccine. Doctor Agate reported that there were no changes in the measles vaccine restrictions, and that the Michigan law will pretty much eliminate measles in this State within the next three years.

Screening Programs. The Committee reviewed the action taken by the 1967 House of Delegates regarding screening programs, and recommended to The Council that Item 3 of the "Guidelines for Health Screening Tests" be deleted inasmuch as screening procedures are being done in hospitals, by non-tax-supported institutions, and in some physicians' offices, and a fee is charged. The Council approved the re-wording of Item 3 in the "Guidelines."

Whooping Cough. The Committee reviewed the work being done in Michigan in connection with whooping cough in pre-school age children and those in the upper grades in high schools, and the attempts to work out a system where florescent antibody and culture tests are made available to all physicians.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC RELATIONS

Brock E. Brush, MD, *Chairman*

Workable, realistic public relations projects were developed and carried out this past year by the MSMS Committee on Public Relations and MSMS staff members — working closely with MSMS officers and committees, and also with component society officers and local public relations committees.

The Report of The Council includes brief references to several MSMS public relations and communications efforts.

The state committee this past year again sought to develop broad guidelines that the staff could implement by working with newspaper reporters and editors, with radio and TV executives and staffers, with printers and artists, with educators, with civic leaders, with politicians and elected state and federal officials, etc.

Career Recruitment: Every day this past year MSMS has been involved with continuing efforts to inform young people and their parents about the excellent career opportunities in medicine and health. MSMS again provided staff assistance and financial support to the Michigan Health Council for the continuance of its Health Careers Mobile. The Health Careers Mobile, with many new exhibits, visited county fairs, schools, college campuses, hospitals and spent considerable time in the Detroit inner city. Equally as important, MSMS continued its distribution of the authentic AMA "Horizons Unlimited" career handbook. Hundreds of books, with the eight special insert pages of Michigan information, were distributed to schools, colleges, youth-serving clubs and agencies, county health departments, and other outlets. Radio tapes, news releases, etc., all supplemented the MSMS desire to increase the health manpower available to serve the people of Michigan.

1967 Community Health Week: MSMS cooperated again with the AMA-sponsored Community Health Week, with the support in Michigan of the Michigan Health Council and the Michigan Association of the Professions. Major focus was on Michigan health manpower needs, with several county medical societies cooperating to present local programs before schools and with civic groups.

Quackery Education: MSMS sponsored two quackery education conferences this past year, one in Detroit during the MSMS Conference on Michigan Health Planning, and the other in Lansing for invited leaders from the Legislature, agencies, health organizations, etc. The MSMS Council in June adopted a new program in quackery education to reach Michigan children and adults.

Other Special Education Efforts: The Public Relations Committee and staff worked closely with several MSMS committees during the year in educational efforts. Informed physicians were placed before conventions and on radio and television programs, and copy was prepared especially for newspapers and magazines. The subjects included eye care, examinations for campers, pap tests, measles, inoculations, mental health, medical aspects of sports, abortion, poison, smoking-health, driver safety, and others.

Michigan Association of the Professions Formula Television Program: The PR Committee recognizes the many medical-related programs that have been produced by MAP over its weekly Formula television program over WJIM-TV in Lansing. Many MSMS officers and MSMS members, expert in various fields, have appeared as guests with Moderator Hugh W. Brenneman on the TV program.

Liaison with Woman's Auxiliary to MSMS and the MSMAS: Both the state Woman's Auxiliary and the Michigan State Medical Assistants Society provided MSMS with valuable assistance in legislation, education, and communications. The state Auxiliary and the local units were especially helpful again in career recruitment and the Medical Assistants worked to improve physician-patient relationships.

Distribution of Pamphlets and Films: Seldom did a week go by this past year that MSMS did not provide an educational film for some school assembly or civic meeting, or that MSMS did not distribute educational printed materials to teachers, professors, ministers, club leaders, legislators. As in the past, MSMS took advantage of the many fine publications produced by the AMA, Michigan Health Council, Michigan Council on Smoking and Health, AMPAC, etc. The films were utilized from the universities, national health associations, government, etc.

MSMS Radio Tape Series: MSMS continued to produce and mail 15-minute tapes about medicine and health each week to about 40 Michigan and midwest radio stations, thanks to the efforts of the MSMS Committee on Scientific Radio and WUOM at the University of Michigan. MSMS members discussed medical matters and good health practices. This is one of many on-going, quality MSMS public relations efforts that many physicians know little about.

Newspaper Cooperation: Almost every week, MSMS sent news material to Michigan newspapers, and to special writers from magazines and out-of-state newspapers. Close contact was maintained again with the 20 scientific writers on Michigan newspaper staffs.

Health-O-Ramas: MSMS and the three county medical societies in the large Detroit metropolitan area cooperated with the Michigan United Fund to support the career recruiting efforts of the four Health-O-Ramas held in the Detroit area. The Health Careers Mobile was a feature at each of the four week-long civic events.

Summary: The MSMS Public Relations Committee is proud of its work and efforts in so many different fields, and appreciates the excellent support it received this past year.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RESPIRATORY DISEASES

Richard A. Rasmussen, MD, *Chairman*

The Committee met with a representative of the Michigan TB and Respiratory Disease Association and reviewed mutual programs of medical and professional education and will cooperate in a program to emphasize to physicians the advantages of TB testing and prophylactic treatment of TB patients in physicians' offices.

The Committee is cooperating with the Committee on Public Health and the Committee on Cancer in formulating an educational program on cigarette smoking and health for presentation to The Council.

In the smoking and health field, the Committee is concerned with the education of school children and the cooperation of physicians in giving talks on this subject; has recommended full cooperation with the various groups and organizations having money to help in the education of the general public; and will consider ways of encouraging clean-up of cigarette advertising via publications, radio and television, especially when such advertising is aimed at youth.

The Committee has recommended that its original statement on air pollution previously approved by The Council be re-affirmed:

> "The Michigan State Medical Society, through its Committee on Respiratory Diseases, officially endorses the principle of reasonable and scientific study directed toward the sensible control of the major problems of air pollution, whether this be the dusts or wastes of industry, the products of combustion of gasoline or oil (automobiles) or the combustion products of home heating and burning equipment, or of smoking tobacco. All of these may have potential effect on man via the respiratory system and are, therefore, of concern to the physician, especially as they are known to affect health adversely."

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RURAL MEDICAL SERVICE

Robert E. Rice, MD, *Chairman*

The Committee has cooperated with the Michigan Health Council in its placement program, promoted the health career mobile, endorsed and implemented community health week, and attempted to influence the educational environment to improve the image of general practice and promote understanding of the realities of practicing in various sized communities. Resolutions were made promoting the training of personnel for emergency medical services and asking the medical schools to adopt preceptorship programs. The Committee is co-sponsoring, with the Michigan Health Council, a study as to why physicians choose their areas of practice and why they do not go to others. Other activities included the attendance and sponsorship of career conferences.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

William J. Ledger, MD, *Chairman*

This report is limited to a report on the radio program "Prescription for Health." This is a weekly fifteen minute program that had been sponsored by the State Medical Society. It is carried by at least fifteen radio stations in the State of Michigan. During the past year, the interviews have focused upon a number of problems of current medical interest. We have had programs on the problems of marijuana and LSD, genetics, the problems of septic abortion, newer forms of contraception, organ transplantation, obesity, inherited anemias, poisoning in the home, hearing defects, and current management of erythroblastosis fetalis. This wide range of subject material, I believe has been of interest to the listening public. In the future year, we plan to do a series on some medical implications of the traffic accident problem in this country. It is hoped that this will be an interesting and provocative series for the listeners.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report and urged the Committee to expand its efforts to include more stations and to make attempts to seek prime air time for its programs.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON THERAPEUTIC ABORTION

Howard R. Williams, MD, *Chairman*

Immediately subsequent to the adoption in 1967 of Resolution No. 40, as amended, directing that MSMS "work toward the revision and liberalization of the Michigan abortion laws," the House of Delegates recommended a formation of an MSMS ad hoc committee to review all available studies on the subject of therapeutic abortion and requested a report of findings to the 1968 House of Delegates.

The Delegates adopted the following reference committee report:

"In the opinion of your Reference Committee:

"1. Since therapeutic abortion is a current medical issue;

"2. Since therapeutic abortion is a departure from some medical philosophic concepts;

"3. Since therapeutic abortion is an emotionally charged issue;

"4. Since the subject of therapeutic abortion has been studied by: a) The American Law Institute; b) the American Medical Association, and those states in which a new program has been activated; c) by the American Psychiatric Association; d) by the Michigan Bar Association; e) and since a tentative position has already been rendered by MSMS in its August 28, 1967 testimony before our State Legislature;

"Your Reference Committee recommends the formation of an MSMS ad hoc committee to formulate a position statement on therapeutic abortion, incorporating all of the above studies, and to report their findings to this House of Delegates at its next regular session."

This ad hoc committee was duly appointed by the President of MSMS and, as charged, reviewed pertinent recommendations developed by the American Medical Association, the Michigan State Bar, the American College of Obstetricians and Gynecologists and several others. Legislation in this area unsuccessfully presented to the 1967 Michigan State Legislature was also studied, along with the testimony given thereon by affected state agencies and interested private groups and individuals.

Having considered the subject in depth, the committee discussed it in great detail and consonant with its charge by the House of Delegates and the President of MSMS recommends that the following statement on the liberalization of abortion laws be adopted by the 1968 House of Delegates as the present policy of the Michigan State Medical Society in regard thereto:

"Therapeutic abortion is a medical procedure. Accordingly, the Michigan State Medical Society recognizes its responsibility to render available scientific medical information with respect to therapeutic abortion to legislators, authorized committees, the public and, finally and most importantly, patients. Nowhere in the progression of therapeutic abortion legislation or practice should sight be lost of the fundamental principle that the primary decision belongs to the patient. This decision must be based upon an informed understanding of the nature and consequences of the therapeutic abortion, and should be coupled with the informed consent of the husband, if any, and the parents and/or legal guardian if the patient is a minor.

"The Michigan State Medical Society respectfully recognized that some physicians, because of moral or religious grounds, oppose liberalization of the therapeutic abortion laws. Therefore, no physician should be compelled, directly or indirectly, to perform a therapeutic abortion.

"In view of the above, the Medical Society believes that therapeutic abortion should be legally authorized subject to the following conditions:

"1. The procedure must be performed in a hospital licensed by this state; and

"2. Two other physicians, who must be medical doctors or doctors of osteopathy licensed in this state, chosen because of their recognized professional competence, must examine the patient and concur in writing that one of the three following conditions exists: a) There is documented medical evidence that continuation of the pregnancy may threaten the health or life of the mother, or b) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or c) There is documented medical evidence that continuation of a pregnancy, resulting from alleged statutory or forcible rape or incest, may constitute a threat to the mental or physical health of the patient, and the prosecuting attorney of the judicial district in which the alleged rape or incest occurred attests in writing over his signature that there is cause to believe that the alleged violation did occur."

The foregoing statement, it will be noted, emphasized the affirmative in certain circumstances as contrasted with a statement opposing therapeutic abortion except under certain circumstances. The ad hoc committee recommends that this statement be approved by the House of Delegates.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered the reports and recommended adoption of the first seven paragraphs and acceptance of the remaining paragraphs, as amended, as follows:

> **In view of the above, the Michigan State Medical Society believes that therapeutic abortion may be authorized subject to the following conditions:**
>
> **1 — A licensed medical or osteopathic physician perform the abortion in an accredited hospital licensed by the State.**
>
> **2 — Two other doctors of medicine or osteopathy concur in writing that one of the following conditions exists:**
>
> - **a) The abortion is deemed necessary to preserve the life of the pregnant female; or**
> - **b) The abortion is deemed necessary to preserve the physical or mental health of the pregnant female; or**
> - **c) That the infant may be born with incapacitating physical deformitory or mental deficiency; or**
> - **d) That three doctors of medicine or osteopathy believe that the pregnancy resulted from forcible rape or incest.**
>
> **3 — MSMS does not condone the concept that an abortion be performed on demand for any unwanted pregnancy or as a means of birth control. We do believe, however, that in determining whether or not there is a risk to the pregnant woman's life or health, account must be taken of the patient's total environment, considering such factors as parity, contraceptive failure, socio-economic stress, or marital or family stress when a woman does request a therapeutic abortion.**

The foregoing statement, it will be noted, emphasizes the affirmative in certain instances as contrasted with a statement opposing therapeutic abortions except under certain circumstances.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON VENEREAL DISEASE CONTROL

Frank B. Bicknell, MD, *Chairman*

1966-67 Committee Activity. The Committee's meeting of last year resulted in four of its recommendations being disapproved by The Council, with one recommendation referred back to the Committee.

The Committee's recommendation concerning serologic reporting of every positive STS still does not meet with the approval of The Council and will be reconsidered by the Committee at its next meeting.

The Committee agreed with The Council's disapproval of its recommendations concerning the reporting of venereal disease to local health departments and the requirement that all admissions to the in-patient services of hospitals receive an admission blood test for syphilis.

In considering last year's recommendation regarding the Government of Michigan recognizing its responsibility in the diagnosis, treatment and control of venereal disease, and to make meaningful appropriations toward this end, the Committee adopted a new recommendation, as follows: "Because 50% of the cases of reported gonorrhea and 84% of the reported cases of infectious morbidity of syphilis, come from the City of Detroit, and because the State of Michigan, at this time, provides only 0.5% of the financial support for the venereal disease control program in the City of Detroit, it is apparent that the City of Detroit suffers from a shortage of financial help. In addition, it appears that other local health departments, county and city, also suffer from a shortage of space, personnel and equipment, to deal with the ever expanding problems of venereal disease control, and that federal and local resources have proven to be inadequate. Therefore, the Committee requests The Council to recommend to the Michigan Department of Public Health that it involve itself, to a greater degree, in the control of venereal disease." This recommendation of the Committee was approved by The Council.

Educational Articles. The Committee has arranged for its members to submit articles and news notes for publication in *Michigan Medicine* and the other MSMS publications. The Committee has also recommended that the MSMS Public Relations Department continue the educational thrust done in October and November of 1966.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

19. Reports of House of Delegates Committees

COMMITTEE ON CERTIFICATES OF COMMENDATION

Marjorie Peebles Meyers, MD, *Chairman*

The MSMS House of Delegates established the "MSMS Certificates of Commendation" at its 1961 session. The Delegates instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first such "Certificates of Commendation" to four distinguished Michigan doctors of medicine who had been recommended by the House of Delegates Committee. The first four honorees were Jerome W. Conn, MD, Ann Arbor; G. D. Cummings, MD, Lansing; Charles S. Kennedy, MD, Detroit; and Robert L. Novy, MD, Detroit.

In 1963, the House of Delegates approved the report of the Committee and presented Certificates to Forest D. Dodrill, MD, Bloomfield Hills; Charles J. Jentgen, MD, Detroit; John M. Sheldon, MD, Ann Arbor; and Homer H. Stryker, MD, Kalamazoo.

The 1964 House of Delegates acted to present the certificates to Goldie B. Corneliuson, MD, Lansing; John S.

DeTar, MD, Milan; Robert Heavenrich, MD, Saginaw; Norman F. Miller, MD, Ann Arbor; E. Gifford Upjohn, MD, Kalamazoo; and Orus R. Yoder, MD, Ypsilanti.

In 1965, the House of Delegates approved Certificates to Fred J. Hodges, MD, Ann Arbor; Traian Leucutia, MD, Detroit; and Remus J. Robinson, MD, Detroit.

In 1966, the House presented awards to Arthur C. Curtis, MD, Ann Arbor; Lionel L. Davis, MD, Mt. Pleasant; Mark Marshall, MD, Ann Arbor; Harold J. Meier, MD, Coldwater; Ralph H. Pino, MD, Detroit; Alfred B. Swanson, MD, Grand Rapids; and Harry A. Towsley, MD, Ann Arbor.

The 1967 House of Delegates presented Certificates of Commendation to Frank J. Busch, MD, Saginaw; W. H. Huron, MD, Dickinson-Iron; Frederick Margolis, MD, Kalamazoo; David Sugar, MD, posthumously, Wayne; Raymond W. Waggoner, Sr., MD, Washtenaw; Charles H. Wright, MD, Wayne.

This year the Committee is proud to present for the consideration of the 1968 House of Delegates the names of five distinguished Michigan doctors of medicine for Certificates of Commendation. They are, alphabetically, A. Fleming Barbour, MD, Genesee; Harry L. Clark, MD, Mason; John M. Dorsey, MD, Wayne; Fred C. Sabin, MD, Marquette; and Wilbur D. Towsley, MD, Midland. Each was nominated by his county medical society, and was considered by the Committee along with other county nominations.

* * *

Brief biographic information follows about each man:

A. FLEMING BARBOUR, MD, Genesee

Born Elkhart, Indiana, July 28, 1909; Pre-medical education, Michigan State University, 1932; Medical degree, University of Michigan, 1936; Internship, Hurley Hospital, Flint; Residency, University of Michigan Hospital; Postgraduate, Rackham Graduate School, University of Michigan; MS Degree in Ophthalmology.

Twenty-eight years in practice in Flint; specialty Ophthalmology.

Hospital staffs: Hurley, Chief of the Department of Ophthalmology; also on McLaren and St. Joseph Hospital staffs.

Lieutenant Commander, U. S. Navy, 1943-46.

Medical Memberships: Member, Genesee County Medical Society, President in 1953-54; Member, AMA and Michigan State Medical Society; Member, American Board of Ophthalmology, American Academy EENT, Detroit Ophthalmology Society, Saginaw Valley EENT Association; Past President of Flint Academy of Surgery.

Community Service: Now State Chairman of YMCA World Services Program; Vice-Chairman, Board of Trustees of the Court Street United Methodist Church in Flint; Vice-President, Flint City Club. Former President of the following organizations — Flint Red Feather Fund; Greater Flint Council of Churches; Flint Committee on Alcoholism; University of Michigan Club of Flint. Former member of the following boards of Directors — Genesee County Chapter of the American Red Cross, Flint Family Service Agency, Flint Chamber of Commerce, Citizens Advisory Committee to Flint Board of Education, and other groups. He is a private sponsor of the Flint College and Cultural Development Program.

HARRY L. CLARK, MD, Mason County

Born Kingsville, Ohio, October 8, 1886; University of Michigan Literature School, 1906-1907; attended Medical School 1907-1909, leaving to teach high school for four years, assistant to Doctor Carl Huber in U. of M. Anatomy Department 1913-1917; completed A.B. in 1915, his A.M. in 1918 and his Medical Degree in 1919.

Following graduation from medical school, Doctor Clark became assistant professor of pathology and bacteriology at the Detroit College of Medicine in March 1919; appointed professor of bacteriology and clinical pathology in 1922 and continued until 1949, when appointed professor emeritus of that WSU department.

From January 1949 until 1957, Doctor Clark was director of clinical laboratories at Hackley Hospital, Muskegon; from 1957-1967, he was director of the laboratory at Paulina Stearns Hospital in Ludington; now is medical director of the Mason County Medical Care Facility.

Medical memberships; now president of the Mason County Medical Society; formerly a member of the Wayne County Medical Society and the Muskegon County Medical Society; active in other medical groups.

Member, Rotary Club, Masons, Shrine, Elks. Honored as "Optimist of the Year" in 1962 at Ludington.

JOHN MORRIS DORSEY, MD, Wayne County

Born Clinton, Iowa, November 19, 1900; Pre-medical education, University of Iowa with B.A. and M.S. Degrees; Medical Degree, University of Iowa, 1925; Internship, University of Iowa Hospital; Residency, University of Iowa Hospital; Postgraduate education, University of Vienna in psychiatry.

Hospital Affiliations: Harper, Receiving, Children's, Veterans Administration Hospital; Chief of Staff at McGregor Center.

Joined Wayne State University Medical School faculty in 1946; former professor and chairman, Department of Psychiatry. Now, "WSU University professor."

Author of Foundations of Human Nature, Living Consciously, Illness and Allness, The Growth of Self Identity, and many scientific articles.

Advisory psychiatrist to the Detroit Youth Commission.

FRED C. SABIN, MD, Marquette County

Born in Little Falls, N. Y., May 6, 1924; A. B. Degree from Syracuse University, and MD Degree from Albany (N.Y.) Medical College; M.S. Degree in ophthalmology from the Mayo Clinic and the Graduate School of the University of Minnesota; Fellow in ophthalmology at the Mayo Clinic from 1954 to 1957.

Served in U. S. Army, 1943-46, including 18 months in European Theatre.

Has practiced in Marquette since 1957. Affiliated with St. Lukes and St. Marys hospitals in Marquette.

Past President of Marquette-Alger County Medical Society; member of AMA and MSMS; Diplomate of the American Board of Ophthalmology, a Fellow of the American Academy of Ophthalmology and Otolaryngology.

Member of the Northern Michigan University Board of Trustees; member of State Board of Registration in Medicine; past chairman, Marquette County Republican Committee; former board member, Marquette Chamber of Commerce; member, Rotary Club, American Legion, Mason.

WILBUR DEAN TOWSLEY, MD, Midland County

Born June 7, 1897, Midland, Premedical Education, Kalamazoo College, B.S. Degree; Medical Degree, University of Michigan 1923; Internship, Grace Hospital, Detroit.

Has practiced in Midland 45 years. Father was Frank A. Towsley, MD, pioneer Midland physician; his brother, Harry A. Towsley, MD, is professor of pediatrics and chairman of the department of postgraduate medicine at the University of Michigan; and his brother, Charles Towsley, DDS, is a dentist in Midland.

Medical Memberships: Midland County Medical Society, President in 1936; Member of MSMS and AMA.

Served on State Boxing Commission in 1939.

Served on Midland Selective Service Board for more than 10 years.

Member of Midland Rotary Club for 36 years and Midland Elks.

Received "Book of Golden Deeds" award from the Midland Exchange Club, in 1962, when he was cited for having delivered more than 6,000 babies in Midland County, for helping many children and families in financial need, and for helping many students through medical school.

Keenly interested in fishing and hunting, Doctor Towsley is a Life Member of the Midland County Sportsman Club and a member of the Michigan United Conservation Club.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert S. Ideson, II, MD, *Chairman*

Proposed Amendments re Procedures for Amending Bylaws. Following the one-day Special Session of the House of Delegates in February, 1968, when the Bylaws were amended, The Council received suggestions that existing amendatory provisions of the Bylaws be reviewed. Legal Counsel was asked to suggest clarifying language and the entire matter was referred to the Constitution & Bylaws Committee.

The Committee concluded that the founding fathers probably intended that amendments really be put over for studied consideration and did not envisage the House holding two meetings minutes apart for the purpose of amending the Bylaws.

Therefore the Committee recommends the following amendments to Chapter 9, Section 1 — Amendments: (New language in caps)

> Sec. 1 AMENDMENTS — PROCEDURE — These Bylaws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table UNTIL THE NEXT SESSION, UNLESS, BY UNANIMOUS CONSENT OF THE DELEGATES PRESENT AND VOTING, SUCH TIME REQUIREMENT IS WAIVED, IN WHICH EVENT THE SAID AMENDMENT MAY BE VOTED UPON AT THE NEXT ~~for one~~ meeting of the House of Delegates. THE AMENDMENT OR AMENDMENTS TO these Bylaws ~~and any amendments thereto~~ become effective immediately upon adoption.

Proposed Review of Constitution. It became evident during the 1968 Special Session that there were apparent language conflicts between the MSMS Constitution and its Bylaws. So much confusion existed that Legal Counsel had to interpret points in each document for the benefit of the entire House. He stated to the Delegates at that time that the Constitution, written when MSMS was organized, properly served as the document expressing MSMS goals, purposes and reasons for being. In addition, it contained a few general statements re structure which are defined and clarified in the Bylaws. Then, in 1910, MSMS incorporated and, in so doing, filed with the State its statement of purpose in its incorporation papers. Thus the need for a Constitution disappeared, although no real problem occurred until 1968.

Over the years, the Bylaws have been continually refined and clarified, but the Constitution remains, unheeded and unneeded, since the organization's purposes are now outlined in the incorporation papers.

Legal Counsel therefore suggested to the Delegates in February that the House might well consider the abolition of the Constitution and transfer of any desired statements into the operating Bylaws. The Speaker concurred that the Constitution and Bylaws Committee should consider the suggestion.

The Committee has discussed the matter and generally favored the idea of reviewing the need for and value of the Constitution. It was specifically pointed out that such a study did not include a rewriting of the Bylaws. Clarifying amendments might be found necessary, but no more so than during any annual review.

The Committee was particularly sensitive to potential misunderstanding of the high purpose and limited scope of the proposed study. It feared that misunderstanding would produce suspicion of motives and thus doom the project before it began. Therefore, the Committee chairman agreed to have introduced a resolution in behalf of the Committee alerting the House to the Committee proposal and seeking House concurrence.

The Committee therefore specifically recommends that such a study be conducted, that progress on the study be reported periodically and a proposed revision be presented to the House, possibly in 1969, with final action possible by 1970 or 1971.

Correspondence re Elections. The Judicial Commission corresponded with the Committee suggesting that it consider revision of the method of electing Councilors. The Committee discussed the matter and alternatives to the election by the House. No action was taken.

Suggested Study of Methods of Membership Transfer. Since problems do occur when a member transfers from one component medical society to another, The Council has suggested that this matter might be studied with an eye to clarifying Bylaws language. The Committee has this on its agenda.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of this report with the following amendments:

"The proposed amendment to Chapter, 19, Section 1 of the Bylaws be amended by deletion of the words 'by unanimous consent,' and the insertion of the words 'by consent of 75 percent of.' "

"In regard to the proposed review of the Constitution... your Reference Committee would recommend a continuing review of the Constitution but not with a view of its abolition."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL STAFF SURVEY OF HOSPITALS

Rosser L. Mainwaring, MD, *Chairman*

No business came up before this Committee. The Committee did not meet.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended the report be accepted.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROCEDURES OF THE HOUSE OF DELEGATES

Noyes L. Avery, MD, *Chairman*

This Committee has functioned each year since 1963 for the purpose of reviewing the operations of the House of Delegates and formulating recommendations to the Speaker designed to improve the efficiency of that body wherever possible.

The foremost guideline of the Committee has always been its priority placed upon the provision of adequate time for the conducting of the major business of the House itself, so that Delegates may have ample opportunity to fully consider and debate matters brought before them. The Committee is unanimously persuaded that experience has shown that the volume of business has become such that *more time is needed* for the deliberation and reporting of reference committees.

The Committee notes that since 1965 the deadline for submitting resolutions has been fixed at the third session (Monday night) except by unanimous consent of the Delegates. It is felt that an intensified effort should be made to encourage all to submit their resolutions before the House convenes, so that they may be printed and studied by Delegates in advance. For the 1968 meeting, however, the Committee recommends that no resolutions be accepted after the *second* session (Monday morning) except by consent of two-thirds of the seated Delegates. While still permitting the introduction of resolutions which may be deemed necessary while the House is in session, it is felt that this change in the order of business will advantage all Delegates by providing more deliberative time. This will be more easily accomplished when it becomes possible to start the sessions one week later than has been the case in the past, allowing more time for county societies to meet in the early Fall (see recommendations of this Committee in 1967).

It has been stated above that the Committee feels that the House has reached the point where it needs more overall time in which to function. This time may be added by holding the first session commencing at noon on Sunday rather than Sunday evening; it may be added by meeting on Wednesday morning (when the scientific meetings have commenced). Although the Committee is not now recommending any major time addition or rescheduling of the order of business of the House, it suggests that in future years commencement at noon on Sunday may be preferable to commencing on Sunday evening or extending the meeting to Wednesday noon. Under such circumstances resolutions would be submitted before the close of the second session (Sunday evening) with provision for exceptions.

The Committee also noted that, although the President of MSMS is elected by the House of Delegates, it has been many years since the House itself has had the honor of conducting his formal inauguration. Feeling that the Delegates would be enthusiastic about doing so, and convinced that a ceremony befitting the investiture of the MSMS President can best be performed before his peers at a specially designated meeting of the House, the Committee is recommending that this ceremony take place during a new function, a dinner meeting on Tuesday evening. The State Society Night program formerly held on Wednesday evening, during which the President has been inaugurated for the past several years, will be revamped accordingly.

It is recommended that the dinner meeting of the House on Tuesday evening be designated the fifth session, preceded by a preprandial commencing at 5:30 pm, and be held at 6:00 pm, ending at 8:00 pm with the sixth session of the House. It is further recommended that attendance at the dinner be determined by the Speaker at his discretion, and that certain other appropriate business of the House also be transacted at this time, including the designation of Michigan's Outstanding Physician, awarding of MSMS Certificates of Commendation, and other awards of similar stature. The Committee further recommends that all honored guests attending the House meeting be invited to, and introduced at, this dinner meeting.

Finally, the Committee notes that the Michigan Medical Service corporate meeting will be conducted during Tuesday morning and end with a luncheon during the 1968 meeting, rather than continue into Tuesday afternoon. The Committee approves this change, feeling that it will expedite the business of the House itself, providing better scheduling for reference committee meetings, and hopes that the MMS meeting itself can be expedited particularly by devising a speedier method of certifying electors.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, accepted the report and recommended further implementation of its suggestions be made as soon as possible.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE

JOHN G. SLEVIN, MD, *Chairman*

Because of the marked increase in malpractice claims in recent years, the House of Delegates established the Committee on Professional Liability Insurance in 1966. The present Committee investigated what is being done in other states to lessen the frequency of such suits.

Probably the most widely discussed program is the *Joint Attorney-Physician Review Panel* which was initiated more than ten years ago in Pima County, Arizona. This is a joint panel of lawyers and physicians set up by the local Bar Association and the County Medical Society. It is a pre-trial hearing with the plaintiff and the defendant physician and their attorneys presenting the evidence. The panel finds either that there is or is not substantial evidence of malpractice. If the answer is "yes" and if an equitable claim adjustment cannot be reached out of court, the medical society agrees to produce expert medical witness at the trial.

Our Committee found that a negative verdict by the Joint Attorney-Physician panel did not preclude the plaintiff going to court. Among the hazards to the defendant physician was the exposure of all the records of the case to the plaintiff's lawyer, making the defense against the malpractice claim more difficult. Our Committee noted that in 1967 premiums for professional liability in Arizona rose fifty percent, the highest increase in the country.

A number of other states have tried the Pima County Panel system only to abandon it because it did not achieve its purpose, namely, a reduction in the number of malpractice claims and increased the cost of professional liability insurance.

The New Jersey Plan was considered. It is set up under a rule of the New Jersey Supreme Court and consists of a joint panel of lawyers and physicians with a retired judge presiding. All records of the hearing are confidential and cannot be turned over to another lawyer or the courts. If the panel decides against the claimant, his attorney must withdraw from the case. However, the plaintiff can obtain another lawyer and take the case to court. A report from the New Jersey State Medical Society on the operation of the plan was favorable. However, there was not enough data at present to evaluate the effectiveness of the New Jersey Plan.

The Oregon State Plan was also studied in depth. The state medical society has sponsored malpractice insurance through private underwriters since 1933. This was on a single premium policy until 1967 when the increase in claims and the amount of settlements and court awards forced a change to a differential premium based on the field of practice. Premiums varied from $190.00 to a high of $693.00. The high rate was for anesthesiologists, neurosurgeons, obstetricians, gynecologists, orthopedic surgeons, plastic surgeons, and otolaryngologists who perform plastic surgery. This corresponds with the new category established by the National Bureau of Casualty Underwriters which determines premium rates on professional liability insurance for its affiliated companies. The NBCU blamed the premium increase on the rising cost of malpractice claims especially in these specialties.

The NBCU indicated that its affiliated companies sustained ever increasing losses which amounted to $140.00 for each $100.00 in premiums; that losses and expenses for surgeons totaled $151.00 for each $100.00 in premiums.

According to reports published in the AMA News, the insurance rates for physicians' and surgeons' professional liability insurance has been raised during the past year in 38 of the 50 states as follows: Arizona, 50%; Washington, 48%; California, 32%; Colorado, Delaware, Hawaii, North Carolina, Puerto Rico, Utah, 30%; Florida, 26.3%; Minnesota, Texas, 25%; New York, 21%; Maryland, Michigan, Montana, New Mexico, Oregon, Pennsylvania, Rhode Island, Virginia, 20%; Alabama, 16%; Arkansas, Missouri, Wisconsin, 15%; Connecticut, Georgia, Idaho, Iowa, Kansas, Kentucky, Ohio, Oklahoma, South Carolina, Tennessee, West Virginia, Wyoming, 10%; New Hampshire —10%.

Ontario and most Canadian provinces, it was noted, have a much lower incidence of malpractice claims. Inquiry was made why this is so. It seems that under Canadian law, when a plaintiff files a malpractice suit, he is required to post a bond covering court costs and attorneys' fees. If he loses his suit, the bond is forfeited. Our legal advisors explained that in Canada the legal profession is not allowed to work on a contingent fee basis whereas this is the customary procedure in American jurisprudence. The Committee was informed that the contingent fee system seeks to give the poor man his day in court and is approved by the majority of American lawyers. Legal advice was that the chances of adopting the Ontario plan in Michigan was nil.

Action being taken by the California Medical Association to lead to a better "professional liability atmosphere" in that state was considered. The CMA sponsored six professional liability bills in the state legislature. Several of these bills were considered as worthy of introduction in the next session of the Michigan Legislature and will be noted under Recommendations.

Educational Programs for Physicians. A survey of the programs of the various states which have had committees to study the malpractice problem reveals that education of the physician is needed so that he may avoid the common problems leading to malpractice claims. Members of this Committee from Wayne County reported that as a result of meeting with lawyers who defend eighty percent of the malpractice claims in the Detroit Metropolitan area, the need to educate the physician in medico-legal matters was, in their opinion, paramount. They indicated that more malpractice claims originate because of loose talk or criticism by physicians about the actions of other physicians, than from any other cause.

RECOMMENDATIONS:

1. That county medical societies, and in large areas, hospital medical staffs, be urged to hold at least one meeting annually devoted to medico-legal problems conducted by an attorney knowledgeable in the field, with emphasis on procedures to lessen the causes for malpractice suits.
2. That the MSMS Legislative Committee formulate a bill to be introduced at the next session of the Michigan Legislature to exempt from subpoena or compulsory disclosure of its actions or proceedings committees of hospitals, state or local medical societies all information and reports furnishing such committees for statistical, scientific, educational or medical study or research directed toward the reduction of morbidity or mortality, utilization, audit of medical care, etc.
3. That physicians, particularly those in the high risk category, be urged to consider carrying excess professional liability, over and above their regular professional liability coverage, the so-called "umbrella policy," which provides at least $1,000,000 over present coverage. It was noted that a number of malpractice awards during the past year have far exceeded the usual $100,000 coverage normally carried by most high risk insurees. They have varied from $200,000 to as high, in one instance, as $1,400,000. Since the cost of such supplemental coverage can be substantially reduced by group insurance through medical societies, as has been demonstrated by some of the larger county medical societies, it is further recommended:
    a. That the MSMS Committee on Professional Insurance Plans investigate the possibility of establishment of such a group supplemental personal catastrophe policy for members of MSMS.
    b. That the MSMS Committee on Professional Insurance Plans continue to investigate feasible plans for reduction of malpractice rates. This study should include the feasibility of MSMS sponsoring a "doctor-owned" professional liability carrier such as was done in 1957 by the Colorado Medical Society and is now being considered by the California Medical Society. It is also recommended that this MSMS Committee make a definitive report to the 1969 MSMS House of Delegates on these items.
4. Because there are many other matters which need study, such as, what can be done to protect the physician from harrassment by nuisance claims; could malpractice claims submitted to arbitration be binding on both parties thus precluding court action, etc., it is recommended that this Committee be continued and become a permanent committee of the House of Delegates.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, accepted the report, recommending: no action on Recommendation One, since this House has already acted on Res. 17; no action on Recommendation Two, since this House has already acted on Res. 46; and approval of Recommendations Three and Four.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO RE-EVALUATE THE DUTIES OF THE PRESIDENT

C. ALLEN PAYNE, MD, *Chairman*

The 1967 House of Delegates adopted a reference committee recommendation that "an ad hoc committee of the House . . . be appointed to re-evaluate the executive duties of the President."

The Committee met on two occasions. It reviewed the present function of the President as outlined in the Bylaws as follows: As the general executive officer of the Society, the President shall preside at General Meetings of the Society, deliver the President's Address, appoint necessary committees where not otherwise provided for and, in addition, shall have a voice in deliberations of the House; shall be an ex-officio member of The Council with vote; and perform such other duties as imposed by the Bylaws.

The Committee recognized that the presidency is the highest honor which the Society can bestow upon a member.

In its study the Committee reviewed several other state medical society organizational structures. Wisconsin, Illinois, and Pennsylvania have presidential responsibilities similar to Michigan. (See Addendum.)

The Committee also reviewed the MSMS tradition and practice of sharing duties and responsibilities among the Speaker of the House of Delegates, the President and The Council Chairman, according to Bylaws direction.

Several proposals for modifying the president's duties were reviewed, and no consensus was established. However, the Committee wished to present to the House a possible solution which it felt deserved more detailed study. The idea, in general, is to provide for the President-elect to serve as Vice-Chairman of The Council, and the Immediate Past President to serve as Chairman of The Council.

Additional study of this and other suggestions is required before any specific recommendations can be made, for undoubtedly a thorough restructuring of the Bylaws would be required before such an amendment could be adopted.

ADDENDUM:

Excerpt from Bylaws of the State Medical Society of Wisconsin:

"The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state, during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful."

Excerpt from Bylaws of the Illinois State Medical Society:

"The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

"The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

"He shall preside at the general scientific meetings of the Society or designate one of the vice presidents to substitute for him."

Excerpt from Bylaws of Pennsylvania Medical Society:

"President. The President shall preside at all general meetings of this Society. At the first meeting of the Annual Session of the House of Delegates he shall deliver an address on such matters as he may deem of importance to this Society, and file a written report on his term as President. He shall be an ex-officio member of all committees, administrative councils and commissions, without the right to vote, and he shall perform the other duties required of his office by the Constitution of the Society and these Bylaws."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended no action, because additional study of this and other suggestions is required before any specific recommendations can be made, for undoubtedly a thorough restructuring of the Bylaws would be required before such an amendment could be made.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO SELECT MICHIGAN'S OUTSTANDING PHYSICIAN

D. Bonta Hiscoe, MD, *Chairman*

The House of Delegates in 1964 took action "to establish annual recognition of Michigan's Outstanding Physician." The resolution outlined this award "as an annual recognition of a member of the profession, who is not necessarily a family physician nor one advanced in years." The delegates also adopted the report of the reference committee which instructed "that the Speaker annually appoint an ad hoc committee to make the selection from nominations submitted by component medical societies."

In 1965 our first outstanding physician was Franklin L. Troost, MD, of Holt. In 1966 William A. Hyland, MD, of Grand Rapids received the award posthumously. Last year Henry Cook, MD, of Flint was our Outstanding Physician of the Year.

The present Committee sent invitations to each component medical society, seeking nominations. The Committee carefully evaluated the many accomplishments and contributions of a number of very worthy nominees.

During our deliberations we drew up a set of guidelines. Briefly, they follow:

1 — Big city vs. outstate politics had no bearing on this matter.

2 — MSMS represents all doctors, academic, public health, administrative, as well as practicing physicians, and all fields should be considered equally.

3 — This physician should be outstanding in his own particular field.

4 — This physician should demonstrate a real sense of social responsibility.

5 — This physician should show a sense of loyalty to the medical profession and the Michigan State Medical Society.

6 — This award gives us an opportunity to use the high-power focus on an example of the type of physician MSMS is most proud of.

Your Committee's nominee for this year was born in New York City and attended Hunter College in New York; was graduated from Wayne State University Medical School in 1943; served an internship and a residency in Internal Medicine at Receiving Hospital, and has practiced in Detroit ever since.

Active in medical society work, our nominee is a delegate from the Wayne County Medical Society and an MSMS alternate delegate to the AMA House of Delegates. This doctor is active on several MSMS committees and also in the Wayne County Society, serving several years as an associate editor of the *Detroit Medical News.*

This physician is an excellent teacher and serves as a clinical assistant professor of medicine in Wayne State University Medical School.

Our nominee has a long, impressive record of volunteer service to the people of metropolitan Detroit and Michigan. This physician now serves as a vice-president of the Michigan United Fund, a Board member of Boy's Republic, a Board member of the Michigan Heart Association, a Board member of the Rehabilitation Institute, Treasurer of the Detroit Adventure cultural organization, a member of the Detroit Committee on Alcoholism, a long-time worker for the Detroit YWCA, the Detroit Neighborhood Service Organization, the Michigan Society for Mental Health, and other civic, health and educational groups.

Recently this physician was honored as one of the "Top Ten Detroit Women Who Work."

Her husband serves the Cathedral Church of St. Paul in Detroit as canon. She is the first and only woman member of the Standing Committee for Advice and Counsel to the Bishop of the Diocese of Michigan of the Episcopal Church.

The House of Delegates Committee to Select Michigan's Outstanding Physician of the Year enthusiastically urges the 1968 MSMS House of Delegates to approve our nomination of Doctor Marjorie Peebles Meyers because she is a distinguished physician, medical educator, medical statesman, and a dedicated community leader.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee.

COMMITTEE TO STUDY FINANCIAL STRUCTURE OF MSMS

James D. Fryfogle, MD

The Committee reviewed its 1967 report and reaffirmed the Committee's responsibilities stated therein:

> "It must 1) review all aspects of the financial structure of MSMS, 2) determine that monies are efficiently administered, and 3) assure itself that funds are adequate for the job to be done. The Committee decided not to comment on the worth and value of projects or activities since these are annually reviewed by the House through reports from The Council and committees."

The study plan for 1968 was much the same as in 1967, except that since this Committee reports every year, rather than at the former three-year interval, the Committee believed it need not report its detailed 1967 study of the operational mechanics of the MSMS budgeting and control system.

The Committee did review thoroughly the current MSMS Financial Report for the nine months ending August 31, 1968, reviewed projected operating budgets for 1969 and 1970, and devoted a major portion of its study time to the status and operation of the MSMS Asset Management Plan.

The Committee was satisfied that the monthly financial reports provide the Finance Committee and The Council with adequate information to maintain expense control and make informed financial policy decisions. It also was noted that the financial control system would produce a balanced budget again in fiscal 1968.

In addition, the Committee studied preliminary figures developed by staff, projecting operating budgets for 1969 and 1970. Briefly, the figures showed a normal increase in income, but a greater increase in projected expense. The Chairman produced examples of 1968 cost increases which have an effect on the budget:

	1967	1968	% increase
First class postage	5¢	6¢	20%
White punched mimeo paper	$1.44/ream	$1.58/ream	10%
Colored punched mimeo paper	$1.52/ream	$1.65/ream	9%
Stencils	$3.20/quire	$3.45/quire	8%
Groundskeeping	$3.25/hour	$4.00/hour	23%
Window-cleaning	$58/month	$63.80/month	10%

The bulk of the Committee's study was devoted to the new Asset Management Plan which was approved by the House in Special Session in February, 1968.

Doctor John Ylvisaker met with the Committee and went into detail regarding the implementation of the program since approval in February.

Briefly, the funds obtained by mortgaging the building will be apportioned to three MSMS funds, maintained as separate entities, with purposes and goals as follows:

Operating Fund.

a. To maintain adequate funds for day-to-day operating expenses of the Society on a pay-as-you-go basis.

b. To invest surplus, during peak income periods, in short-term fixed-dollar securities to provide maximum interest return and to provide for the programmed release of these investments to meet operating needs during low-income months.

Capital Reserve Fund.

a. To augment present Capital Reserve to $250,000.

b. To provide for maintenance of Reserve at a minimum level equal to:

1. Two-months operating expenses.
2. Additional sum equal to accumulated depreciation plus 10% of building contents.
3. Additional sum equal to 10% of replacement value of headquarters building.

c. Investment of funds:

1. 50% in fixed-dollar negotiable securities providing maximum interest income.
2. 50% in high-grade negotiable securities providing income and growth.

d. Replenishment and augmentation of fund principal by income and growth of the fund or by appropriation from operating funds when necessary.

Creative Reserve-Capital Protection Fund.

a. Created from balance of mortgage monies after providing for needs of Operating Fund and Capital Reserve Fund.

b. Investment of funds:

100% in bona fide investment vehicles to provide balanced portfolio of stocks, bonds, real estate or others resulting in growth, income and stability.

c. Maintenance and augmentation of fund by growth of asset value or by reinvestment of profit, gain or unused interest or dividend income.

d. Distribution of income:

1. To provide other than ordinary service to Society members.
2. For creative Society projects consonant with Society aims and objectives.
3. For research appropriate to 1 and 2.
4. For expenses incurred in management of the fund.

The investments are superintended by a Council-elected Board of Managers composed of physicians and financial experts. It reports to the Finance Committee and The Council.

The Committee agreed with the fund goals and plans and was satisfied with the exercise of authority and control over the funds by the Board of Managers and The Council, and praised the Treasurer for his experienced guidance of the entire plan.

CONCLUSIONS:

1. The MSMS Asset Management Plan is efficiently operated and represents a substantial improvement in the MSMS approach to present and future fiscal responsibility. The Committee approves of the manner in which the plan is being operated and in the goals the funds are set up to achieve. Particularly the Committee is impressed by the safeguards built into the fund management by Treasurer Ylvisaker and his Committee.
2. After a review of the 1967 year-end Financial Report and the 1968 nine-months report, the Committee believes the financial structure of MSMS is adequate to provide the funds to do the job required. In the long term, however, the Committee sees income rising more slowly than expense and a dues increase seems certain by 1970 or 1971.

THE REFERENCE COMMITTEE on Ways and Means, S. N. Kelso, MD, Chairman, recommended approval of the report, seconding the Committee's commendation of the performance of our Treasurer, Dr. John Ylvisaker.

The HOUSE adopted the report of the Reference Committee.

RESOLUTIONS

THE HOUSE adopted a motion that no new resolutions be introducd after the Monday morning meeting except by consent of two-thirds of the seated delegates.

RESOLUTION 1

Objection to Unnecessary Paperwork
Introduced by Donato F. Sarapo, MD

Whereas, the ever mounting volume of documentation required in the modern practice of medicine greatly diminishes the time available for patient care, and

Whereas, the medical profession already is becoming desperately short of time and physicians to care for the nation's sick people, and

Whereas, the number of certifications, signatures, and diagnoses on every laboratory and X-ray request covered by Michigan Hospital Service, Medicare, and various other insurance carriers adds a great deal of unnecessary documentation in an apparent attempt to make certain requested examinations are necessary, and

Whereas, if any questionably necessary procedures were to be ordered by the attending physician, they almost certainly would be properly documented, therefore be it

RESOLVED: That this House of Delegates of the Michigan State Medical Society instruct The Council of MSMS to advise all insurance companies and carriers operating in the State of Michigan that the members of MSMS consider this requirement of signatures, certifications, and diagnoses on each and every laboratory and X-ray procedure to be detrimental to the best interests of adequate patient care in this State, and be it further

RESOLVED: That this House of Delegates instruct The Council of MSMS to advise these same insurance companies of the desire of MSMS members to have this requirement withdrawn in the best interests of patient care, and be it further

RESOLVED: That this House of Delegates instruct The Council of MSMS to advise the individual members of MSMS that the best interests of patient care will be served by the members no longer providing these unnecessary and time consuming signatures, diagnoses, and certifications effective in the immediate future, and be it further

RESOLVED: That a similar resolution be presented to the House of Delegates of the American Medical Association by the Delegates from MSMS at the earliest opportunity.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman considered Resolution 1 and 61 together, and recommended adoption of the following substitute resolution:

Whereas, there is an ever-increasing burden of unnecessary documentation of medical services by the physician, hospital and fiscal intermediary in Medicare and Medicaid patients, and

Whereas, this detracts from the optimal care of the patient, and

Whereas, this unnecessarily increases the cost of patient care, therefore be it

RESOLVED: That the Legal Affairs Committee of the Michigan State Medical Society exert every effort to bring about the elimination of these unnecessary procedures.

THE HOUSE approved the following substitute Resolved and adopted the substitute resolution as amended:

RESOLVED: That this resolution be presented to the MSMS Council and the AMA House of Delegates at the earliest opportunity.

RESOLUTION 2

Legislation re Malpractice Suits

Introduced by Edward E. Elder, Jr., MD

Whereas, the cost of malpractice insurance has risen so markedly, and

Whereas, the judgments awarded in malpractice suits have reached astronomical figures, and

Whereas, many suits against physicians are nuisance suits designed to obtain money on out of court settlements, therefore be it

RESOLVED: That the Michigan State Medical Society urge the State Legislature of Michigan to enact legislation requiring the posting of a bond by a claimant in a malpractice action, as a step to reducing baseless lawsuits against physicians. For example, a $500 bond filed by the claimant might be awarded the defendant for defense costs, if the verdict is for the defendant physician.

THE REFERENCE COMMITTEE on State & Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution and referring it to The Council for appropriate implementation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 3

Regional Councils of the State Comprehensive Health Planning Commission

Introduced by Robert J. Toteff, MD

Whereas, Public Law 89-749 authorizes regional councils of the State Comprehensive Health Planning Commission, and

Whereas, this Commission will be directing the utilization of federal funds in the local areas, and

Whereas, this Commission will be directing the expansion and building of health care facilities, and

Whereas, the county medical societies through their members will be acutely concerned with working with the directions and decisions of the Commission, and

Whereas, the appropriate information concerning this is not yet available to the county societies, therefore be it

RESOLVED: That the county societies be made cognizant of the role to be played by them in the regional councils of the State Comprehensive Health Planning Commission, and be it further

RESOLVED: That this information with recommendations be made available to the county societies at the earliest date possible following the 1968 House of Delegates Meeting of the Michigan State Medical Society, and be it further

RESOLVED: That the Michigan State Medical Society strongly recommend that the local county societies be involved and take a prominent part in the formation of the regional councils of the State Comprehensive Health Planning Commission, with the aim of having adequate medically oriented representation.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, amended the first Whereas, inserting after the words "Public Law 89-749," the words "as amended by Public Law 90-174," and amended the Resolved section by deleting the third Resolved and amending the first and second Resolved portions to read:

RESOLVED: That the county societies be made cognizant of the role which can be played by them in taking leadership in the regional councils of the State Comprehensive Health Planning Commission, and be it further

RESOLVED: That this information with recommendations by The Council be made available to the county societies at the earliest date possible following the 1968 House of Delegates meeting.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 4

Constitution and Bylaws Committee Report

Introduced by Henry A. Scovill, MD

Whereas, the Constitution and Bylaws Committee report contains an important recommendation relative to clarifying language in the Constitution and Bylaws and the Articles of Incorporation, and

Whereas, the Constitution and Bylaws Committee seeks approval for a proposed review of these three documents, therefore be it

RESOLVED: That this House of Delegates take due note of this recommendation and give favorable consideration to the Committee's report.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval, stating it felt it unnecessary to petition the House to consider any committee report.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 5

Michigan Medical Service Assignments

Introduced by H. T. Knobloch, MD

Whereas, Michigan Variable Fee Policy is completely new and different from previous policies, and

Whereas, a physician will not know the amount which will be paid for his services, and

Whereas, the fees paid under Medicaid by Michigan Medical Service are not a physician's usual and customary fee, and

Whereas, the changes in the policy remove M.V.F. from under the consent decree prohibiting assignment of fees to the physician, therefore be it

RESOLVED: That MMS shall honor assignments of fees to physicians under MVF policies, and be it further

RESOLVED: That if MMS refuses to accept assignments, MMS shall take the proper legal action forthwith to show that MVF is not bound by the consent decree.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution because the assumption in the last Whereas is in error according to Legal Counsel.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 6

Family Planning

Introduced by Robert R. Dew, MD

Whereas, population growth during the first 600,000 years of man's existence was 0.02% per 1,000 years, and only 0.06% per year by the year 6,000 B.C., but the rate of increase in the last three centuries alone has been phenomenal — 0.3% in the period 1650 A.D. to 1750 A.D., 0.9% in the first half of the twentieth century, 2% now and expected to be 2.1% by 1975, and

Whereas, it has been calculated that 100 persons, multiplying at 1% per year for the 5,000 years of human history, would have produced a contemporary population of 2.7 billion persons per square foot of planet land surface (had all lived to maturity and procreated offspring); and

Whereas, war, famine, disease, etc. have in centuries past been checks on population expansion, public health and hygiene and medical advances have been primarily responsible for the relatively recent population explosion, and

Whereas, although public health and medical scientific advances have contributed mightily to longer and better life, they have coincidentally contributed to problems of the greatest magnitude, an example of which is illustrated by the statistical fact that although the economically deprived say that they wish to have fewer children than the economically privileged, they actually have about 40 children per 1,000 population as compared to about 22 children per 1,000 for the well-to-do, and

Whereas, over 250,000 babies are born in the U.S. each year to unmarried women, about 9 out of 10 label their children "unwanted", and

Whereas, although the numbers of unplanned pregnancies in marriage can only be estimated, nonetheless it is a fact that unplanned pregnancies too often produce unwanted and thus rejected, abandoned or battered children, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates go on record as being in favor of universal family planning as an essential element of responsible parenthood, stable family life and social harmony and further that we recommend that each member actively participate to the best of his ability and opportunity.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 7

Need for Cooperation between MSMS and MHA

Introduced by D. Bonta Hiscoe, MD

Whereas, Michigan State Medical Society and Michigan Hospital Association are both very important parts of the medical community as it exists today, and

Whereas, both organizations have a vested interest in the future of medical practice, and

Whereas, both organizations are dedicated to fostering as little government involvement in medicine as possible, and

Whereas, combined efforts are often more effective in problem-solving and more influential in the public forum, therefore be it

RESOLVED: That closer cooperation be actively promoted between MSMS and MHA at both the state and local society levels, and be it further

RESOLVED: That when there are differences between the two societies about medical care or its administration, we make vigorous efforts to resolve these problems between ourselves, to preclude the arbitration of medical debates by the legislature.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, added a third Resolved which read, "RESOLVED: That a liaison committee be established between MSMS and MHA to implement this resolution", and recommended adoption of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 8

Investigation of a Doctor Convicted of a Felony

Introduced by Arnold L. Brown, MD

Whereas, it is vitally important to the health of the citizens of the State of Michigan that the medical profession see that all possible safeguards for their health care be provided, and

Whereas, is is generally agreed that the Michigan State Medical Society is the medical organization with whom such responsibility should rest, and

Whereas, it is agreed that the Michigan State Medical Society has the further responsibility of protecting the interests of medical doctors practicing in Michigan, and

Whereas, the Oakland County Medical Society, on behalf of all physicians in the State of Michigan, feels that in situations in which a medical doctor has been convicted of a felony, even though he may not have been a bona fide member of the Michigan State Medical Society, it should be within the province of the MSMS Judicial Commission to investigate the facts of such a case and to make appropriate recommendations to the Michigan State Board of Registration in Medicine, therefore be it

RESOLVED: That the Michigan State Medical Society empower and instruct the MSMS Judicial Commission to investigate instances such as described above and to make such recommendations as may be necessary to the Michigan State Board of Registration in Medicine for the purpose of safeguarding both the citizens and the practicing doctors of Michigan.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of this resolution for the following reasons: 1) MSMS does not have basic authority or jurisdiction to investigate or make recommendations concerning a civil action against a member or nonmember of MSMS. 2) There are adequate mechanisms available for any citizen to make complaints or recommendations to the State Board of Registration in Medicine concerning physicians accused of a felony. 3) Committee recommends that MSMS inform the public via appropriate news media that this Society has no authority to grant or revoke medical licensure.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 9

Criminal Penalties for Violation of Administrative Rules

Introduced by D. Bonta Hiscoe, MD

Whereas, a revised Michigan Criminal Code will be submitted to the Michigan State Legislature for its consideration during the regular 1969 session of the Legislature, and

Whereas, the final draft of proposed new section 4235 of this new Michigan Criminal Code reads: "A person commits the crime of engaging in a business improperly if, after having once obtained a license, certificate, or permit required for the business, profession, or occupation in which he is engaged or practices, or while engaging in a business, profession, or occupation for which no license, certificate, or permit is required, he intentionally violates any statute or lawfully adopted rule or regulation governing or regulating that business, profession, or occupation. Engaging in a business improperly is a Class C misdemeanor", and

Whereas, this proposed language embodies a major substantive change in that it would classify as a crime, and impose criminal penalties for, the violation of a bureaucratic rule, since criminal penalties have historically only been levied for violation of laws adopted by the elected representatives of the people, and

Whereas, this proposed new major change would establish precedent, and although a "Class C misdemeanor" carries with it upon conviction a maximum fine of $250 and/or a maximum sentence of imprisonment for 30 days, once the violation of a rule adopted by a State agency is established to be a criminal offense the "class" of misdemeanor could be altered, and

Whereas, the traditional penalties for intentional violation of either a statute or a rule regulating a profession have been determined by the appropriate licensing and regulating board, and adequately police the profession and protect the public through power to suspend or revoke licenses, but this proposed new Criminal Code section would make it a criminal offense not only to violate any rule adopted by the licensing authority, but to violate a rule promulgated by any State agency administering programs involving the profession, therefore be it

RESOLVED: That this House of Delegates opposes the making a crime of violation of a rule or regulation adopted by an agency of State government, and be it further

RESOLVED: That this House of Delegates specifically opposes the inclusion of proposed Section 4235 of the revised Michigan Criminal Code, and be it further

RESOLVED: That copies of this resolution be forwarded to all appropriate parties and the Michigan State Medical Society take all further necessary steps to implement the intent of these resolveds.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 10

Pilot Study to Improve Hospital Efficiency

Introduced by Edward J. Tallant, MD

Whereas, the present shortage of physicians is likely to continue into the foreseeable future, and

Whereas, this shortage is of great concern not only to the medical profession, but also to the general public and the Federal government, and

Whereas, despite vigorous efforts to expand the facilities to train more medical students, it is projected that the serious shortage will continue because of our expanding population, and

Whereas, an alternative answer to the problem is to utilize more efficiently the time of practicing physicians, and

Whereas, a major part of modern medical practice is centered in the hospital, where, as everyone knows, there is a great need for streamlining procedures which could make medical care, and the physicians' labors much more efficient, therefore be it

RESOLVED: That The Council of MSMS be instructed to seek a grant for the purpose of conducting a meaningful pilot study on ways and means to make it possible to conserve the time and energy of the medical staff in the care and treatment of patients; to devise new and imaginative methods to reduce the number of personnel required to service patient hospital care; and to investigate and project into the future the use of various automation devices in hospitals that would improve the efficiency, reduce the cost and save on labor in the hospital care of patients.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, deleted the word "automation" from the Resolved and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 11

Seating of Delegates at Special Sessions

Introduced by C. Jackson France, MD

Whereas, questions arose as to who were eligible to be seated at the Special Session of the House of Delegates of the Michigan State Medical Society, held in February 1968, and

Whereas, the Bylaws do not specify whether an alternate delegate seated at the Annual Session of the House of Delegates serves for that session only or whether he assumes the office of delegate until the end of the year, therefore be it

RESOLVED: That the Bylaws Committee of the Michigan State Medical Society submit an amendment to clarify this problem.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate Bylaws changes to amend Chap. 9, Sec. 4, adding the words "and remains a Delegate until the next Annual Session" to the end of the first Sec. 4 sentence.

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 12

Membership Requirements

Introduced by Homer M. Smathers, MD

Whereas, Chapter 2, Section 1 of the Michigan State Medical Society Bylaws requires, "To be eligible for active membership in any component county society, a doctor of medicine must hold an unrevoked license to practice medicine, surgery, and mid-wifery in Michigan," and

Whereas, the word "mid-wifery" is archaic and demeaning to the practice of medicine today, therefore be it

RESOLVED: That the word "mid-wifery" be deleted from Chapter 2, Section 1 of the Bylaws.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate Bylaws changes, amending Chapter 2, Section 1, by deleting from the second sentence the words "to practice medicine, surgery and mid-wifery."

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 13

Exemption of Dues for Hardship Cases

Introduced by Paul R. Dumke, MD

Whereas, each year there are members who are unable to pay their dues because of illness or financial reasons, and

Whereas, many of these physicians are ineligible for Associate Membership and remission of dues, and

Whereas, temporary assistance will enable such physicians to maintain their membership, and

Whereas, the Board of Trustees of the American Medical Association may excuse members from payment of dues provided they are excused from payment of local dues by their component and state associations, therefore be it

RESOLVED: That Chapter 5 of the Michigan State Medical Society Bylaws be amended by addition of the following section:

"Section 8. Hardship Cases: A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness may be excused from payment of dues by The Council, provided the member is fully or partially exempted from the payment of local dues. A member may also be excused from payment of dues because of financial hardship for other reasons, but these must be set forth by the secretary of the member's component society."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate

Bylaws changes, adding to Chapter 5, a new Section 8 as follows: "Sec. 8. HARDSHIP CASES — A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness may be excused, fully or partially, from payment of dues by The Council provided the member is fully or partially exempted from the payment of component society dues. A member may also be excused from payment of dues because of financial hardship, or for other reasons, but these must be set forth by the secretary of the member's component society."

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 14

Separate Sections on Neurology and Psychiatry

Introduced by Benjamin Jeffries, MD

Whereas, there is an increased number of neurologists in Michigan, and

Whereas, the neurologists are desirous of having their own section meetings, therefore be it

RESOLVED: That the Bylaws of the Michigan State Medical Society be amended to establish separate Sections for Neurology and Psychiatry.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented on first reading, appropriate Bylaw changes.

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 15

Uniform National Licensure Examination

Introduced by Luther R. Leader, MD

Whereas, it is archaic that physicians licensed to practice medicine in one state find because of technicalities in the laws of another state they cannot obtain reciprocity and must take the examination of the other state to qualify to practice, and

Whereas, the Federation of the State Medical Boards has attempted to devise a uniform national licensing examination which would be acceptable in all states of the Union, and

Whereas, such a uniform national licensing examination is most desirable and should be adopted without delay, and

Whereas, the Michigan State Board of Registration in Medicine accepts the National Board examination as adequate qualification for licensure, and

Whereas, the Michigan State Board of Medical Examiners in the Basic Sciences does not recognize the National Board examination, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, go on record as favoring and strongly urging the adoption by all states of a uniform national licensing examination, and be it further

RESOLVED: That the Michigan State Board of Medical Examiners in the Basic Sciences accept the National Board examination, seeking whatever changes in the present Michigan law as may be necessary to achieve that end, and be it further

RESOLVED: That the Michigan Delegates to the American Medical Association be instructed to present at the next meeting of the House of Delegates of the American Medical Association a similar resolution in support of a uniform national licensing examination, and be it further

RESOLVED: That a copy of this resolution be sent to the Michigan State Board of Registration in Michigan, the Michigan State Board of Medical Examiners in the Basic Sciences, and the President of the Federation of State Medical Boards.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, deleted the fourth and fifth Whereas and the second Resolved, and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 16

Procedures for Resolving Grievances Against Non-members

Introduced by Laurel S. Eno, MD

Whereas, the county medical society can accept and investigate complaints only against physicians who are members, and

Whereas, there are no facilities available to patients who have grievances against physicians who are not members of the local medical society, and

Whereas, patients of non-member physicians should be protected against unethical practices, and

Whereas, the services, fees and conduct of physicians who are not members should be subject to the same standard of behavior as are members of the Michigan State Medical Society, and

Whereas, under present circumstances Michigan State Medical Society members are subject to criticism for behavior of non-members and have no provision for entering into the review of the activities of such non-members, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society appoint a committee to investigate the problem of grievances against non-member physicians and to recommend methods by which it may be solved.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, changed the Resolved portion to read:

"RESOLVED: That the Legal Affairs Committee be instructed to investigate the problems of grievances against any physician licensed to practice medicine in the State of Michigan and to recommend methods by which they may be resolved."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 17

Educational Program on Professional Legal Responsibility

Introduced by Raymond J. Barrett, MD

Whereas, members of the legal profession who defend the majority of malpractice claims against physicians are unanimous in their opinion that an intensive educational program is necessary to inform physicians and ancillary medical personnel of the legal pitfalls which often lead to suits of malpractice, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, urges all component county medical societies, as well as the medical staffs of all the larger hospitals in Michigan, to devote at least one meeting annually to a discussion of the legal problems of medical care by an attorney competent in the field of malpractice, and be it further

RESOLVED: That the medical staff of every hospital in Michigan be urged to inform all ancillary medical personnel who are concerned with patient care, not to discuss with, or in the presence of, the patient any matters concerned with the patient's diagnosis, treatment or care or the qualifications of any physician on the medical staff.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended approval of the resolution amended to read as follows:

Whereas, members of the legal profession who defend the majority of claims against physicians are unanimous in their opinion that an intensive educational program is necessary to inform physicians and ancillary medical person-

nel of the legal pitfalls involved in patient care which lead to lawsuits; therefore, be it

RESOLVED: That the House of Delegates of MSMS urge all component medical societies as well as the medical staffs of the hospitals in Michigan to devote at least one meeting annually to a discussion by an attorney or other persons competent in the field of legal problems of medical care; and be it further

RESOLVED: That the administrative staff of every hospital in Michigan be urged to inform all ancillary medical personnel who are concerned with patient care not to discuss with, or in the presence of, the patient any matters concerned with the patient's diagnosis, treatment, or care or the qualifications of any physician or nurse on the staff."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 18

Medical Staff Tenure

Introduced by A. H. Hirschfeld, MD

Whereas, the present method of hospital staff appointments which are renewable on a yearly basis can be used by the hospital board of trustees and/or hospital administrators to discourage open and frank discussion and criticism of hospital administration by members of the medical staff, and

Whereas, such open and frank discussion by members of the medical staff is to the best interest of patient care, therefore be it

RESOLVED: That the MSMS House of Delegates favor indefinite tenure of appointment to the medical staff of all hospitals in Michigan after an appropriate probationary period of appointment with termination of appointment to the medical staff subject only to conviction of a felony, revocation of license by the State, conviction of unethical practice by a county medical society or the Michigan State Medical Society, or violation of the bylaws, rules or regulations of the hospital which has been approved by the medical staff, and be it further

RESOLVED: That this resolution be sent to the president of each board of trustees and the president or chief of staff of each medical hospital in Michigan.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles Meyers, MD, Chairman, recommended approval of the resolution after amending the first Resolved to read:

"RESOLVED: That the MSMS House of Delegates favor annual reappointment to the active medical staff; that reappointment shall not be denied except for medical ineptitude, character deficiency, or conviction of unethical conduct."

THE HOUSE added an additional phrase to the first Resolved in the Reference Committee report and adopted the report as amended. The amended first Resolved read:

"RESOLVED: That the MSMS House of Delegates favor annual reappointment to the active medical staff; that reappointment shall not be denied except for medical ineptitude, character deficiency, or conviction of unethical conduct, revocation of license by the State, or violation of the Bylaws, rules or regulations of the hospital which have been approved by the medical staff."

RESOLUTION 19

Establishment of a Legal Section in Michigan Medicine

Introduced by Arthur B. Levant, MD

Whereas, many legal matters of concern to the members of Michigan State Medical Society escape their notice for lack of publicity, therefore be it

RESOLVED: That *Michigan Medicine* establish a medical-legal section to be published at least six times a year with timely articles prepared by attorneys who specialize in legal medicine.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended no official action on the resolution since the Publication Committee had indicated its commitment to this end in 1969.
THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 20

Binding Arbitration in Malpractice Suits

Introduced by John G. Slevin, MD

Whereas, the Professional Liability Committee of MSMS has studied the various arbitration panels, such as the Pima County Plan, whereby defendant physician and plaintiff submit their case to a joint committee of lawyers and physicians to determine the validity of the malpractice claim, and

Whereas, the Professional Liability Committee has found none of these plans is satisfactory because arbitration is not binding on either party, therefore be it

RESOLVED: That the House of Delegates, request the Joint Committee of the Michigan Bar and MSMS, which is now in the process of studying the problem of malpractice to include in its report, due in September 1969, a factual analysis and its recommendations concerning legality, practicability and advisability of establishment by law of a method whereby, if both parties to a malpractice suit voluntarily agree to abide by binding arbitration, it could minimize the number of such suits, lessen the burden of cost, render justice to both parties, hasten settlement, and leave to the courts only the question of the amount of damages if the arbitration board finds in behalf of the plaintiff.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the Resolution with the following substitute Resolved:

"RESOLVED: That the House of Delegates request the MSMS Liaison Committee with the State Bar to include in its report, due in September, 1969, its recommendations concerning the legality and advisability of establishment by law of a method of binding arbitration in malpractice suits."

THE HOUSE amended the substitute Resolved by adding after the words "binding arbitration" the following: "voluntarily agreed to by both parties", and adopted the report of the Reference Committee as amended.

RESOLUTION 21

Water Pollution

Introduced by William Haeck, MD

Whereas, water pollution is an increasingly urgent national problem directly related to a progressively complex industrial and urban society, and

Whereas, the Great Lakes area is a particularly important problem as exemplified by the accomplished decline in Lake Erie and the progressive crisis in Lakes Michigan and Huron and even Lake Superior, and

Whereas, constructive forces in the field of conservation, in government and in industry are opposing the problem of pollution despite many handicaps and opposite pressures, and

Whereas, the medical profession, in its concern for ecology and the *total* environment of modern man, must sustain a resolute continued interest in water pollution as an important cause of bacterial, viral and toxic chemical disease, and

Whereas, pure and abundant water in this area of Great Lakes beauty is an aesthetic necessity for residents and visitors in this era of the longer vacation and the shorter work week, therefore be it

RESOLVED: That a standing committee of MSMS be created to be concerned with water pollution and that shall function with an authoritative and dynamic voice in support of organizations, public and private that are engaged in the war against pollution.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution with the deletion of the words in the Resolved "be created to."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 22

Out-patient Physical Therapy Treatments

Introduced by Frederick S. Gillett, MD

Whereas, there has long been a shortage of adequate physical therapy facilities in most communities in the State of Michigan and likely this will continue for a long time to come, and

Whereas, many hospital physical therapy departments are unable to furnish adequate out-patient physical therapy treatments because of the heavy in-patient demands, and

Whereas, there are many Registered Physical Therapists in private practice who are well equipped to treat patients under the prescription of a Doctor of Medicine or Doctor of Osteopathy, and

Whereas, many insurance companies, including Michigan Blue Cross, now insist that all out-patient physical therapy treatments must be given in a hospital physical therapy department, therefore be it

RESOLVED: That The Council seek the enactment of legislation requiring insurance companies to provide in their policies, giving physical therapy benefits, that these treatments may be provided on an out-patient basis by any Registered Physical Therapist, under the direct specific orders of a Doctor of Medicine or a Doctor of Osteopathy.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended the approval of the Resolution with the substitution of the following Resolved:

"RESOLVED: That The Council request the Health Insurance Council to seek a solution to the problem of providing out-patient physiotherapy by a licensed physiotherapist under the direct specific orders of a Doctor of Medicine or Osteopathy."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 23

Referendum

Introduced by Harvey M. Andre, MD

Whereas, American democratic organization has always been designed to allow the will of the majority of individual members of any organization to determine that organization's policy, and

Whereas, traditionally the total membership of any organization has had the right of referendum concerning any action taken by its duly elected representatives, and

Whereas, the MSMS has traditionally been a democratic organization representing all of the member doctors of medicine in this State, therefore be it

RESOLVED: That Chapter Fifteen of the Bylaws be amended by the addition of Section Three to read:
"Disapproval of any action of the House of Delegates may be accomplished by a direct mail polling of the entire membership of the Michigan State Medical Society upon petition signed by no less than three hundred members in good standing. A majority vote of the entire voting membership disapproving of any action of the House of Delegates shall be final and binding."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution and that the question of referendum by petition including the use of mail ballots be studied by the Standing Committee on Constitution and Bylaws for recommendations to the next House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 24

Publication and Distribution of Minutes of The Council of MSMS

Introduced by Bruce D. Bauer, MD

Whereas, Delegates to MSMS should be well informed of actions of The Council prior to the annual session, and

Whereas, The Council considers matters of considerable import necessary for the proper function of MSMS, and

Whereas, is is the obligation of The Council to render a report to the House of Delegates on matters germane to the Society, and

Whereas, minutes of The Council must be approved, transcribed, then re-evaluated by the Executive Committee, therefore be it

RESOLVED: That the minutes of The Council, after each meeting, be made available to the Delegates prior to their approval by said Council, and be it further

RESOLVED: That these said minutes of The Council be in printed form, labeled confidential, and distributed to the House of Delegates members.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended disapproval of the resolution believing that the intent could be achieved better through closer communication between Councilors and component societies.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 25

Improvement of Ambulance Services

Introduced by Edward E. Elder, Jr., MD

Whereas, a primary contact between the medical care system and patients is the ambulance service, and

Whereas, the medical profession is in a position to help train ambulance personnel, and

Whereas, patients' lives may actually be saved by proper first aid at the scene of accidents or in the ambulances on the way to a hospital, therefore be it

RESOLVED: That this House of Delegates urge the Michigan State Medical Society and each component medical society to take an active interest in training ambulance personnel and in upgrading ambulance service.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 26

Four-Year Medical School at MSU

Introduced by Robert M. Stow, MD

Whereas, the Michigan State Medical Society has, for several consecutive years, through its House of Delegates and Council and in all other practicable ways, strongly urged the expansion of the two-year medical school at Michigan State University to a four-year school, and

Whereas, through the development of the clinical areas of the MSU medical school curriculum, the State of Michigan can most immediately, effectively and economically qualify Michigan State University's present program as a Class A medical school, thus with speed and efficiency increasing the supply of well trained physicians so greatly needed to meet the health needs of our rapidly growing population, and

Whereas, meeting the demand for properly trained physicians is everybody's business; this State Medical Society has long urged, and will continue to urge, that our state move with all possible speed to bring its medical education facilities at the University of Michigan, Wayne State University, and Michigan State University, to full function; lay groups should be established which would take it upon themselves to join MSMS in urging the necessary legislative financial support to bring about this result, therefore be it

RESOLVED: That this House of Delegates once more respectfully urge the Governor and State Legislature of Michigan to proceed with the expansion of the two-year College of Human Medicine to a complete college of medicine at MSU granting the degree of Doctor of Medicine, and be it further

RESOLVED: That The Council of MSMS take immediate steps to develop a group of lay leaders in the State of Michigan who can and will effectively join with us in urging the logical development of the MSU medical education program.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered together Resolutions 26 and 27 and in lieu thereof, submitted the following Substitute Resolution and recommended its approval.

SUBSTITUTE RESOLUTION

The Expansion to a 4-Year Medical School at Michigan State University and its Funding

Whereas, the Michigan State Medical Society has for several consecutive years, through its House of Delegates and Council and in all other practicable ways, strongly urged the expansion of the two-year medical school at Michigan State University to a four-year school, and

Whereas, through the development of the clinical areas of the MSU medical school curriculum the State of Michigan can most immediately, effectively and economically qualify Michigan State University's present program as a fully accredited medical school, thus with speed and efficiency increasing the supply of well-trained physicians so greatly needed to meet the health needs of our rapidly growing population, and

Whereas, meeting the demand for properly trained physicians is everybody's business; this State Medical Society has long urged, and will continue to urge, that our state move with all possible speed to bring its medical education facilities at the University of Michigan, Wayne State University and Michigan State University to full function; lay groups should be established which would take it upon themselves to join MSMS in urging the necessary legislative financial support to bring about this result; therefore be it

RESOLVED: That this House of Delegates once more respectfully urge the Governor and State Legislature of Michigan to proceed with the expansion of the two-year College of Human Medicine to a complete college of medicine at MSU granting the degree of Doctor of Medicine; and be it further

RESOLVED: That the Michigan Legislature be strongly urged to make the required appropriation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 27

Appropriation of Funds for MSU Four-Year Medical School

Introduced by C. Allen Payne, MD

Whereas, MSU's two-year College of Human Medicine has been in operation for two years, and

Whereas, the MSU College of Human Medicine is proving its capacity to recruit faculty of excellence and dedicated to new and community-oriented educational efforts, and

Whereas, the Citizens Committee for Education for Health Care, of the State Board of Education, in 1966 studied Michigan's manpower needs and MSU's capability to became a complete four-year medical school, and

Whereas, the Citizens Committee's recommendation to the State Board of Education was that MSU be authorized to develop a complete four-year medical school, and

Whereas, the State Board of Education, in January, 1967, did act favorably on the Citizens Committee report, and recommended a four-year medical school at MSU, and

Whereas, current surveys of Michigan physicians and hospital administrators, carried out by the Michigan Health Council, indicate that the medical manpower crisis deepens steadily, and

Whereas, the Michigan Legislature has not yet authorized or funded expansion of the MSU College of Human Medicine to a complete four-year school, therefore be it

RESOLVED: That the attention of the Honorable George Romney, Governor of Michigan, be called to this situation, and that he be strongly urged to recommend the appropriation of funds required to begin expansion of Michigan State University's two-year College of Human Medicine to a full four-year medical school during the fiscal year 1969-1970, and be it further

RESOLVED: That the Michigan Legislature likewise be strongly urged to make the required appropriation.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered together Resolutions 26 and 27 and, in lieu thereof, submitted a substitute resolution (see Resolution 26).

RESOLUTION 28

Disability Compensation

Introduced by Noyes L. Avery, MD

Whereas, employee compensation for disability and injury are an increasing problem for the disabled, medical, employer and insurance groups, and

Whereas, real disability problems exist as a result of disease or injury arising out of special conditions of employment, but also disability occurs during, before, or after employment activity which is not or only remotely related to conditions of employment, and

Whereas, there is an increasing tendency for the courts to grant employer compensation for conditions not truly considered related to employment from purely medical, and scientific reasoning, and

Whereas, this type of court action has been influenced by the misfortune of the disabled, and the resulting sympathy and the lack of other means of support and recompense of such disabled persons, and

Whereas, these decisions have often rested on medically meaningless, prostituted or confusing medical testimony and often have been in conflict with factual and responsible medical testimony, and

Whereas, compensation insurance premiums have increased at an inordinate and unfair rate when actual causative factors are considered, and

Whereas, there has been decreasing reliance on credibility of responsible medical testimony by the courts in the matter of causations in cases of employment disability, and

Whereas, the disabled are none-the-less disabled whether or not the disability was caused by or resulted from or aggravated by conditions of employment, therefore be it

RESOLVED: That MSMS, jurists, lawyers, laborers, employers, and insurance carriers cooperate to create more reasonable concepts of disability compensation, and be it further

RESOLVED: That consideration be given to compensation for disability whether or not it be related to special conditions of employment, and be it further

RESOLVED: That MSMS take the initiative in forming a proper commission which will search for a proper solution to this problem and make recommendations toward these ends.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution feeling this was primarily a matter of legal and socio-economic importance and not entirely within the province of the MSMS.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 29

Regional Advisory Committees to Blue Shield

Introduced by W. Kaye Locklin, MD

Whereas, in the past Michigan Blue Shield has had the benefit of the services of five county medical advisory committees to assist in the interpretation of difficult claims and in the adjudication of fees, and

Whereas, these county committees have served only a portion of the state, and

Whereas, there are some component societies without such committees, and

Whereas, there is need for a uniform appeal mechanism throughout the state for the physician in fee disputes with Blue Shield, and

Whereas, there will be a need for local physician involvement in review of utilization of professional medical services and charge patterns, and

Whereas, establishment of committees on a regional basis would make for increased efficiency, therefore be it

RESOLVED: That the MSMS recommend the formation of regional eommittees representative of the medical profession and selected by the component medical societies within each designated region to assist and advise Michigan Blue Shield in the review of claims, the arbitration of fee disputes, and review of utilization frequency and charge patterns.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, amended the Resolved by deleting "designated regions" and inserting "Councilor Districts or combination thereof" and recommended approval of the resolution as amended.

THE HOUSE further amended the Resolved, adding "that the physician representatives on the regional committees will report back to their component medical societies." and adopted the report of the Reference Committee as amended.

RESOLUTION 30

State and County Society Membership for Residents

Introduced by Edward E. Elder, Jr., MD

Whereas, recently the AMA suggested that means be found by which interns and residents could take a more active role in the local and state medical societies, and

Whereas, the Bylaws of the MSMS state that any licensed physician is eligible for active membership in the MSMS and the local societies, and

Whereas, residents are licensed physicians, and

Whereas, many of the decisions made by the local societies and the MSMS will directly affect the interns and the residents when they enter private practice, and

Whereas, the local societies and the MSMS are forums for the expression of new ideas and these new physicians would be another source of ideas and opinions, and

Whereas, many interns and residents may be interested in participating more actively in their local and state societies but are unable to because they cannot afford the dues necessary for active membership, therefore be it

RESOLVED: That the MSMS and the local societies institute a program whereby residents who are in residency programs within the State of Michigan and who hold a permanent Michigan license may become active members with all the rights and privileges thereof of the local society and the MSMS, and be it further

RESOLVED: That dues be at the discretion of the local society but that they be not more than 10 per cent of the dues charged a practicing physician member.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended no action on this resolution since the MSMS Bylaws already provide for full membership for any licensed physician and the resident may become an associate member with no dues if he so wishes.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 31

Protection by Law of Committees of Medical Societies

Introduced by Francis P. Rhoades, MD

Whereas, Public Act. No. 270 of 1967 protects physicians and hospitals from liability for release of medical information to any in-hospital staff committee, used in the course of study for the purpose of reducing morbidity or mortality or to advance medical research and education; and

Whereas, the county medical societies, the State Medical Society and medical specialty societies also have committees to whom medical information is released for the purpose of reducing morbidity or mortality or to promote medical education and research; therefore be it

RESOLVED: That the House of Delegates urges an amendment to Public Act 270 of 1967 to extend the benefits and protection of this law to similar committees of county medical societies, the MSMS and the medical specialty societies.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 32

Compensation for Regional Anesthesia

Introduced by S. N. Kelso, Jr., MD

Whereas, many general practioners and obstetricians have of necessity been administering saddle block or other regional anesthesia in patients for delivery, and

Whereas, malpractice insurance for anyone performing these procedures has recently taken a dramatic rise, and

Whereas, there are many hospitals in the state where anesthesiologists are not available to administer regional anesthesia, i.e. (saddle block or caudal), therefore be it

RESOLVED: That when regional anesthesia is administered by the attending obstetrician, it be a a compensable benefit in all Blue Shield programs.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the following Substitute Resolution:

"Whereas, many attending physicians have of necessity been administering regional anesthesia; therefore be it

"RESOLVED: That Michigan Medical Service be requested to study the feasibility of making regional anesthesia administered by the attending physician a compensable benefit in all Blue Shield programs."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 33

Minor's Consent to Venereal Disease Therapy

Introduced by Eli J. Igna, MD

Whereas, many minors do not seek treatment for venereal disease because they know their parents must be notified to gain consent for treatment; and

Whereas, the highest incidence of venereal disease is in the "under 21" age group; and

Whereas, late treatment results in less cures and more dissemination of venereal disease; therefore be it

RESOLVED: That The Council direct its Legislative Committee to urge the State Legislature to pass a law allowing minors to give their own consent for examination for and treatment of venereal disease.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 34

Use of Computer Techniques by the Board of Registration in Medicine

Introduced by Alexander Blain, III, MD

Whereas, some 600 doctors of medicine are examined each year for a license to practice in Michigan, and

Whereas, the preparation of the examinations requires about 300 hours work by each member of the Board, and

Whereas, the number of eligible applicants will increase by about 25% with the expansion of the Wayne State University School of Medicine and the operation of the Michigan State University School of Human Medicine as a four year school, and

Whereas, there is an increasing demand for the examination of individuals and small groups at various times between regular examinations given in January and June, and

Whereas, this increasing work load requires the use of improved and advanced techniques to render acceptable service, therefore be it

RESOLVED: That the MSMS does hereby recommend that the Board of Registration in Medicine explore all possibilities and adopt such modern and advanced techniques as, in its opinion, may best serve to expedite its lawful function of examination, licensure and regulation of the practice of medicine in Michigan, and be it further

RESOLVED: That an adequate fee, commensurate with the cost, be charged for such service.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 35

Deletion of the American Medical Association Reinstatement Fee

Introduced by Brock E. Brush, MD

Whereas, Chapter III, Section 1 (E), of the Bylaws of the American Medical Association states: "Members of the American Medical Association who have been dropped from the membership roll for non-payment of annual dues cannot be reinstated until such indebtedness has been discharged, and such indebtedness shall apply only to the one year of delinquency;" and

Whereas, the payment of this reinstatement fee of one year's dues plus current dues to the American Medical Association (a total of $150 in 1968) may be a financial hardship to the physician and deterrent to the reinstatement of his membership; and

Whereas, the physicians may be members of their local medical society and MSMS without membership in AMA, and

Whereas, members of component medical societies should be encouraged to be members of the American Medical Association; therefore be it

RESOLVED: That the Michigan Delegates to the AMA be instructed to introduce at the 1968 Interim Meeting an appropriate resolution to delete the membership reinstatement fees as specified in Chapter III, Section 1 (E) of its Bylaws.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 36

Physicians' Hospital Privilege Act

Introduced by Leon Rottenberg, MD

Whereas, The MSMS House of Delegates has passed 1966 Resolution 55 – Hospital Staff Privileges for All Ethical Licensed Physicians; and

Whereas, the AMA House of Delegates unanimously passed 1966 Resolution 34 that "all doctors of medicine regardless of their field of practice be accorded hospital privileges commensurate with their training, experience, and demonstrated competence; and that in the public and professional interest every ethical licensed doctor of medicine who needs and desires them have staff privileges in at least one accredited, full facility community hospital,"; and

Whereas, the MSMS House of Delegates in 1967 instructed the Legal Affairs Committee to study the feasibility of developing a Physician's Hospital Privilege Act; therefore be it

RESOLVED: That this House of Delegates recommend that an ad hoc committee of the House be appointed to study the Physicians' Hospital Privilege Act and report back to the 1969 House.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended no action on the resolution since this subject is under active consideration by the Legal Affairs Committee.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 37

Establishment of Committees to Evaluate Hospital Provided Care

Introduced by Loyal W. Jodar, MD

Whereas, claims are constantly being made as to the advanced level of medical care now available; and

Whereas, hospitals and their boards have appointed numerous committees to check on the quality of professional care rendered by medical staff members; and

Whereas, at present complaints and suggestions of individual physicians regarding inadequacies of hospital provided care receive insufficient attention; and

Whereas, the Joint Commission on Accreditation of Hospitals requires establishment of various committees to evaluate professional patient care; therefore be it

RESOLVED: That MSMS recommend to the Joint Commission on Accreditation of Hospitals that they require formation of Hospital Care Committees in all approved hospitals, composed of physician members of the staff, to review all aspects of hospital provided patient care.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, suggested the following changes in the third Whereas, to read: "Whereas, at the present time complaints and suggestions of physicians regarding a hospital's failure to provide care of an acceptable professional standard receives insufficient attention from Administration", and delete the fourth Whereas and revise the Resolved to read:

"That the House of Delegates authorize The Council to appoint a committee to investigate such complaints when

petitioned by a majority of the active staff of an accredited hospital and to make appropriate recommendations."

The Reference Committee then recommended the approval of the resolution as amended.

THE HOUSE did not adopt the report of the Reference Committee, but instead adopted the Resolution in its original form.

RESOLUTION 38

Practice Opportunities in Michigan

Introduced by Fred E. Caumartin, MD

Whereas, the MSMS House of Delegates has repeatedly urged the State Legislature to support the financial requests of the three medical schools in this State; and

Whereas, the people of Michigan are experiencing a serious shortage of private medical practitioners; and

Whereas, the hospitals of Michigan with educational programs are having increasing difficulties in obtaining physicians to fill their many house officer positions; therefore be it

RESOLVED: That the House of Delegates urge the deans of the three medical schools in Michigan to acquaint and urge the medical students in their various schools to consider seriously the advantages and the opportunities of the hospitals in this state and further to consider entering practice in the State of Michigan.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, changed the Resolved by inserting the words "and faculties" after the word "deans" and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 39

Blue Shield Advertising

Introduced by Thomas M. Flake, MD

Whereas, some of the Blue Shield advertising for its new Variable Fee Program has been confusing to both physicians and patients; and

Whereas, such confusion may result in errors, problems and criticism; and

Whereas, it is in the best interest of Michigan Medical Service, the doctors and the subscribers that these contracts be clearly understood by all; therefore be it

RESOLVED: That the House of Delegates urge the Board of Directors of Michigan Medical Service to review all advertising and public announcements prior to their release.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read: "That the House of Delegates urge the Board of Directors of Michigan Medical Service to carefully review advertising policy."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 40

Rescinding of Abortion Laws

Introduced by Henry A. Scovill, MD

Whereas, the current abortion laws of the State of Michigan are very restrictive so that only a very few women may receive legal abortions; and

Whereas, all data indicate that despite these laws many women do receive criminal abortions and in the process many times seriously endanger their physical and mental health, and

Whereas, most studies indicate that the average woman who receives an abortion is married and in all other ways a law-abiding citizen, and

Whereas, all of the current abortion law reform bills are limited in their scope so that only a very few women would have the right to obtain an abortion, and

Whereas, the right to bear a child should be primarily determined by the pregnant woman and her husband, and

Whereas, the abolishment of the abortion laws would not force anybody who had moral or religious misgivings into either having or performing an abortion, therefore be it

RESOLVED: That MSMS urge the Michigan Legislature to rescind the abortion laws wherein they apply to pregnancies of less than thirteen weeks gestation.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution with the following amendments: Elimination of the third Whereas, and changing the Resolved portion to read, "RESOLVED: That the Michigan State Medical Society urge the Michigan Legislature to so alter the abortion laws that the criminal code will not apply to abortions performed by a licensed medical or osteopathic physician in an accredited hospital licensed by the State."

THE HOUSE adopted the amended resolution, after further amending it by striking the word "pregnant" from the fifth Whereas, so that it reads: "Whereas, the right to bear a child should be primarily determined by the woman and her husband."

RESOLUTION 41

Study of Osteopathic Physician Training Programs

Introduced by Clifford W. Colwell, MD

Whereas, osteopathic physicians care for a significant percentage of the population of the state of Michigan, and

Whereas, pressures are building within and outside of the medical and osteopathic professions to make their integration and cooperation a logical reality, and

Whereas, if this integration is to be accomplished, there must first be found a sound and equal basis upon which to judge and compare the background, training and competence of each of the two professions, and

Whereas, reports available at this time indicate that the training and experience offered at osteopathic medical colleges do not meet the minimum requirements for accreditation ordinarily applied to medical schools in the United States, and

Whereas, there is now no known good, available data on the training and experience offered in osteopathic internships and residencies, and

Whereas, Michigan has more osteopathic physicians than any other state in the Union, therefore be it

RESOLVED: That MSMS sponsor a study to provide information and evaluation concerning the current training of osteopathic physicians in their various schools and in their internship and residency training programs, and be it further

RESOLVED: That a special committee be appointed to implement this type of study promptly.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended that this resolution be referred to The Council for consideration.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 42

Registered Nurses

Introduced by Clifford W. Colwell, MD

Whereas, the ever-increasing population is placing more and more demand upon the medical and paramedical profession, and

Whereas, technological advances in the medical field require highly trained paramedical personnel, and

Whereas, refinements in patient care as well require highly trained and skilled paramedical personnel, therefore be it

RESOLVED: That MSMS encourage, foster and promote the training of registered nurses and the programs therefore, and be it further

RESOLVED: That MSMS ought to preserve and elevate the training of registered nurses and the programs therefore, and be it further

RESOLVED: That MSMS actively, through its staff, Council, and House of Delegates, discourage legislation that would in any way degrade the profession and dignity of a registered nurse or in any way equate the status of a registered nurse with persons of less training.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 43

Balanced Patient Concept for Nursing Homes

Introduced by Alfred Golden, MD

Whereas, all general hospitals are operated on the balanced patient load concept; the strictly intensive-care type of hospital is not economical or feasible; and

Whereas, modern nursing homes have been constructed and organized on the balanced load concept; and

Whereas, experience has shown that this principle results in the lowest possible per diem cost for the patient and the community; and

Whereas, the principle of separating the basic nursing home from the skilled nursing home will result in a downgrading of staff for the care of patients and also result in the undesirable frequent transfer of patients between facilities; therefore be it

RESOLVED: That the House of Delegates approve the principle of the balanced patient load concept for nursing homes; and be it further

RESOLVED: That the House of Delegates call this to the attention of the State Health Commissioner and the new committee appointed by the Governor to study nursing homes and their rates.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 44

Revision of Blue Shield Method of Payment to Physicians

Introduced by Sidney E. Chapin, MD

Whereas, the present profile method of determining fees only substitutes a range of fees for a set fee schedule; and

Whereas, in many areas in the country Blue Shield plans have found that complying with the individual physician's billing; without a fee schedule or arbitrary screening, has proved economical, equitable and predictable; and

Whereas, all county medical societies have an established procedure for arbitration of unfair fees; therefore be it

RESOLVED: That the House of Delegates recommend to Michigan Medical Service that it amend its present methods of payment to physicians, and adopt a method of payment based on the individual physician's billing, for group subscribers, individual subscribers and those supported by the Medicare-Medicaid program.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE did not adopt the Reference Committee report, but directed the Speaker to refer the resolution to a committee for further study.

RESOLUTION 45

Medical Aspects of Crime

Introduced by Ralph H. Pino, MD

Whereas, three years ago the Wayne County, Michigan State and the American Medical Association House of Delegates voted in favor of an educational program to inform the public on the causes and consequences of crime and delinquency from the medical standpoint; and

Whereas, little has been done to implement this resolution; and

Whereas, crime in the street presently is of political importance in this country; therefore be it

RESOLVED: That the MSMS House of Delegates reaffirm the resolution presented to the AMA House of Delegates in 1966 which states "that the American Medical Association is urged to continue and expand its efforts in crime prevention by initiating educational programs for physicians and the public and by appropriate studies on the medical aspects of crime prevention;" and be it further

RESOLVED: That a copy of this resolution be sent to the President of the American Medical Association.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 46

Immunity from Subpoena of Records of Medical Society Committees

Introduced by Charles E. Darling, MD

Whereas, Act No. 17 of the Public Acts of 1968 (Michigan Hospital Licensing Law) provides in Section 12 (2) that records of hospital committees, in review functions, are confidential and shall not be available for court subpoena; and

Whereas, the various committees of the state and county medical societies of Michigan have review functions similar to those of hospital committees; therefore be it

RESOLVED: That The Council instruct the Legal Affairs Committee to prepare legislation to grant review committees of Michigan State Medical Society, the component county medical societies and medical specialty societies immunity from subpoena of records by the Courts of the State of Michigan and to seek introduction of such legislation in the 1969 Session of the Michigan State Legislature.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 47

Qualifications for "Life Member", Michigan State Medical Society

Introduced by W. Kaye Locklin, MD

Whereas, requirement of today's medical education is more demanding timewise, and

Whereas, doctors of medicine are spending more years in academic training before beginning the practice of medicine, and

Whereas, there is a trend to retirement at an earlier age, and

Whereas, to qualify for "Life Member" in MSMS, a doctor must have attained the age of 70 years or have been in practice for 50 years, therefore be it

RESOLVED: That Chapter 2, Section 6, paragraph (a) of the Bylaws be studied by the Reference Committee on Constitution and Bylaws for modification more in keeping with the needs of the times.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution and referral of the general subject of life membership to the Constitution and Bylaws Committee for study.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 48

Para-Medical Education Program

Introduced by W. Kaye Locklin, MD

Whereas, the Subcommittee on Para-Medical Education of the Education Liaison Committee has been involved for the past three years in the development of a program for the education of physicians' assistants, with significant progress, therefore be it

RESOLVED: That this Committee be commended for its diligent efforts and urged to expedite the completion of this worthwhile educational project.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read: "That this Committee be commended for its diligent efforts and urged to continue this worthwhile educational project."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 49

Division of Blue Cross/Blue Shield Premium

Introduced by Donald N. Sweeny, Jr., MD

Whereas, in 1959 (Resolution 30), the MSMS House of Delegates recommended that all premium notices of Blue Cross/Blue Shield be itemized so that the subscribers may know what percentage of their premiums are used to defray hospital costs and for remuneration to physicians; and

Whereas, Blue Cross/Blue Shield continues to bill jointly; and

Whereas, the increase in health costs emphasizes the need for this differentiation between hospital and physician charges; therefore be it

RESOLVED: That the House of Delegates recommend to the Board of Directors of Michigan Medical Service that it announce to its subscribers annually the percentage of the premium paid to Blue Cross and the percentage to Blue Shield.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 50

Commendation to Dr. Ralph Pino

Introduced by J. C. Danforth, Jr., MD

Whereas, Dr. Ralph Pino has served the Michigan State Medical Society as a delegate for 23 sessions during the last 35 years, and

Whereas, Dr. Pino is continuing to serve as a delegate to the Michigan State Medical Society; therefore be it

RESOLVED: That the House of Delegates highly commend Dr. Ralph Pino for his many contributions to the activities of the Michigan State Medical Society, to the medical profession, and to the public it serves.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 51

Adjudication of Medical Problems

Introduced by J. A. Witter, MD

Whereas, the county medical society has established mechanisms for the review and arbitration of any problem that cannot be settled directly by the physician and the patient, and

Whereas, the county medical society has the right to seek the cooperation of its members in mediating these problems and has the procedure for exacting discipline if indicated; and

Whereas, there is adequate protection of the rights of both the physician and the patient through the appeal procedures of the Michigan State Medical Society; therefore be it

RESOLVED: That the House of Delegates recommend to the Board of Directors of Blue Shield that matters relating to ethics, professional conduct, mediation and discipline of physicians be referred to the county medical society for adjudication.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended that the resolution be disapproved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 52

Liaison with SAMA and MSMS

Introduced by Marjorie P. Meyers, MD

Whereas, the Student American Medical Association (SAMA) chapters at the University of Michigan, Wayne State University and Michigan State University meaningfully represent well over 90% of all medical students, interns and residents at their respective schools, and

Whereas, SAMA is now devoted to Concern, Commitment and Action in many fields of crucial importance to American Medicine today as is the Michigan State Medical Society, and

Whereas, SAMA would greatly benefit from the advice and counsel derived from close association and liaison with MSMS, therefore be it

RESOLVED: That MSMS officially establish liaison with the SAMA chapters at the University of Michigan, Wayne State University and Michigan State University by providing an official delegate to each of these chapters' advisory boards, and be it further

RESOLVED: That MSMS continue its financial support of these SAMA chapters and their increasing scope of activities and concerns by increasing the annual MSMS contribution to these SAMA chapters from $300 to $500.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution after amending the first Resolved to read: "That MSMS officially establish liaison with the SAMA Chapters in all accredited schools."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 53

Liaison with Medical Students, Interns and Residents

Introduced by Stuart Gould, Jr., MD

Whereas, there exists a definite lack of communications between the medical societies at the local, state and national levels, and the medical students, interns and residents concerning the purpose, operation and activities of the medical societies, and

Whereas, there exists no convenient way for medical students, interns and residents to obtain this information from the medical societies, and

Whereas, the establishment of better communications between the medical societies and the medical students, interns and residents will help to eliminate the lack of understanding between these groups, therefore be it

RESOLVED: That an official pamphlet be developed, published and distributed to all medical students, interns and residents concerning the purpose, operation and activities of the medical societies, and be it further

RESOLVED: That MSMS institute a program whereby medical students and interns may assume an affiliate membership with the local medical society in Michigan without all the rights and privileges of the local society, and be it further

RESOLVED: That a similar resolution be presented to the AMA House of Delegates by the delegates from MSMS at the earliest opportunity.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, approved the resolution in principle with the deletion of the first Resolved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 54

State Medical Examiner's Senate Bill

Introduced by Donald Finlayson, MD

Whereas, the State Medical Examiner's Bill (Senate Bill No. 479 of March 2, 1967), died in the State Legislature of Michigan this year, and

Whereas, the Senate Bill No. 479 wasn't adequate for implementation for proper services for people of the State of Michigan; and

Whereas, it has always been the responsibility and the custom of the medical profession to serve the people through its profession (as has well been demonstrated by the performance of practicing physicians in the past by their free services and time given to teaching hospitals, universities, and indigents), and

Whereas, the medical profession still recognizes its responsibility of service to the people, therefore be it

RESOLVED: That MSMS formulate, promote, and support a new Medical Examiner's Bill to replace the present Coroner's System for the entire State of Michigan, with equal protection under the law for all citizens of the State of Michigan irrespective of locality of residency, and be it further

RESOLVED: That such a bill consider pathologists as the obviously best qualified group of physicians to study, to be trained, and to take over the functions of the medical examiner, and be it further

RESOLVED: That pathologists who are employed and who are earning a proper living, and who would only serve as part-time medical examiners in the various counties of the State of Michigan be encouraged to offer their services to the State of Michigan without remuneration; that all such money procured from all such various counties (average annual Coroner's expense to various counties) be utilized to run the entire Medical Examiner's System to include an adequate increase in salaries for full-time medical examiners and toxicologists now in the state employment and now overworked and underpaid (as such a service would only be comparable to the time and free services rendered throughout the years to society by practicing physicians on the staff of teaching hospitals and universities), and be it further

RESOLVED: That MSMS work through proper channels for an adequate budget to run such a statewide Medical Examiner's System, thus made possible by the free services of pathologists, and be it further

RESOLVED: That state troopers of the Michigan State Police be used as assistants to the Medical Examiners; so that the state budget to run the Medical Examiner's System will be within reasonable reach through proper legislation. (It is to be recognized that it is the custom of state troopers to appear at the scene of such cases), and be it further

RESOLVED: That all efforts and skills of the MSMS be utilized to carry out these resolutions for the making of a new medical examiners bill for the protection of the people of the State of Michigan, with equal protection under the law for all citizens to seek and find the impartial truth, related to the certification of death affecting such cases involved with compensation, insurance, accidents, civil court suits, and criminal cases; all of which circumstances carry a tremendous impact upon our civil rights and protection and upon our entire massive national economy.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended that no action be taken on the resolution but that it be referred to The Council.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 55

Support for Michigan Variable Fee Program

Introduced by Robert M. Stow, MD

Whereas, the Michigan State Medical Society has, in previous years on three occasions, passed resolutions of commendation and/or endorsement of Michigan Blue Shield (i.e., Resolution 19 of 1944, Resolution IV-13 of 1945, and Resolution 56 of 1966); and

Whereas, MSMS approved the "Heidenreich-Bowman" Resolution in 1956 urging total participation of Michigan State Medical Society members in Michigan Blue Shield's plans, and

Whereas, there currently is no official indication of the State Society's support and endorsement of Michigan Blue Shield's Variable Fee Program, and

Whereas, the current Michigan Blue Shield Variable Fee (MVF) Program reflects essentially those known wishes of the Michigan State Medical Society and the medical profession in general concerning scope of benefits and payment mechanism (i.e., 1967 MSMS House of Delegates Resolutions Nos. 4, 5, 32, 36; and 1966 Resolution Nos. 16, 22, 26, 29, 35, 41 and 66); therefore be it

RESOLVED: That MSMS endorse the Michigan Variable Fee Program, both as to scope of benefits and payment mechanisms, and urge its membership to actively support the program in all aspects, and be it further

RESOLVED: That MSMS recommend that every physician member display to his patients and the community his own support and endorsement by formal participation in the MVF Program.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution with the following amendments:

Amend the first Resolved to read, "That MSMS endorse the Michigan Variable Fee Program, both as to scope of benefits and payment mechanisms, and urge its membership to actively support the program.

Delete the second Resolved.

THE HOUSE adopted the amended resolution after further amending the first Resolved to read: "That MSMS endorse the Michigan Variable Fee Program in principle."

RESOLUTION 56

Practice of Laboratory Medicine

Introduced by Frank B. Walker, MD

Whereas, the MSMS House of Delegates adopted Resolution 37 in 1965, stating that "the operation of a medical laboratory as defined represents the practice of medicine and that a medical laboratory should be supervised and directed by a licensed physician," and

Whereas, there is currently considerable lay, political, social, and corporate interest in medical laboratory activity, including the solicitation of specimens from physician's offices in Michigan, and

Whereas, such activty has been considered unethical by the AMA, the MSMS and various state and national specialty organizations, therefore be it

RESOLVED: that the 1968 House of Delegates reaffirm its 1965 action, and authorize The Council to take such steps as are necessary to implement its position, and be it further

RESOLVED: that a copy of this resolution be forwarded to the various state and national specialty societies, to the entire membership of the MSMS, and to the AMA.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended that the second Resolved be deleted, and that the resolution be adopted as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 57

Nursing Education

Introduced by Jack Hoogerhyde, MD

Whereas, the acute shortage of trained nursing personnel throughout the country has posed a serious problem in patient care in our hospitals, and

Whereas, the high standards for accreditation of hospital nursing schools, as demanded by the American Nursing Association, has increased costs of maintaining a nursing school and strained hospital budgets to new heights, and is reflected in higher hospital costs, which must be passed on to the patient, and

Whereas, many nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education, thus compounding the paucity of trained nurses, and

Whereas, the American Nursing Association would close all diploma, hospital-based nursing schools, transferring nursing education to the college campus, and

Whereas, experience has shown that graduates of two-year community colleges are not competent to assume responsibility on hospital wards without further supervision and training, and

Whereas, graduates of four-year baccalaureate programs in nursing theory may also require further supervision and training in responsible bedside nursing, and

Whereas, the emphasis on collegiate nursing education with the "phasing out" of all hospital nursing schools, can only result in a greater shortage of nurses, and

Whereas, recent legislation (H.R. 15757, the Manpower Training Act of 1968) has been passed by Congress, this act providing a subsidy to financially distressed nursing schools in the amount of $15,000 per year and is obviously intended to alleviate the stress on hospital finances and provide more trained nurses, and

Whereas, this important legislation is a step in the right direction, therefore be it

RESOLVED: That the Michigan State Medical Society:

1. Give its heartiest approval to H.R. 15757, and urge the legislative body of the American Medical Association to follow up and urge that subsidies to hospital nursing schools be further increased;

2. Voice its opposition to any plan to "phase out" hospital nursing schools;

3. Encourage the American Nursing Association to support four-year bacalaureate nursing training for only those applicants who possess the aptitude and desire to engage in nursing education.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered Resolutions 57 and 59 together and recommended the following Substitute Resolution, entitled "Nursing Education":

"Whereas, the acute shortage of trained nursing personnel throughout the country has posed a serious problem in patient care in our hospitals, and

"Whereas, many nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education, thus compounding the paucity of trained nurses, and

"Whereas, at the present time there is no unified academic program for training nursing personnel, and

"Whereas, the licensed practical nurse, the two-year associate degree nurse trained in our community colleges, the three-year diploma nurse trained in our hospital nursing schools, and the four-year baccalaureate university degree nurse are all separate entities and do not complement each other academically, and

"Whereas, recent legislation (H.R. 15757, the Manpower Training Act of 1968) has been passed by Congress, this Act providing a subsidy to financially distressed nursing schools, and is obviously intended to alleviate the stress on hospital finances and provide more trained nurses; therefore be it

"RESOLVED: That the Michigan State Medical Society:
1. Approve the intent of H.R. 15757 and encourage the House of Delegates of the American Medical Association to urge increased subsidies to hospital nursing schools.
2. Voice its opposition to ANY plan to "phase out" hospital nursing schools; and be it further

"RESOLVED: That the State Board of Education be requested to bring together all organizations concerned with nursing training to establish a unified academic program for all levels of nursing training aforementioned, and to establish a "master plan" whereby credits earned at each level of training be recognized and applicable to the next higher level of training; and be it further

"RESOLVED: That the State Board of Education consider integration of hospital nursing schools and community and state colleges in such a program."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 58

Prohibition of Cigarette Advertising on Television

Introduced by Fred C. Brace, MD

Whereas, television commercials are being beamed into our homes in ever-increasing volume, and

Whereas, children of ten spend many hours viewing this advertising on the television, and

Whereas, in a child's formative years he is very impressionable, and not able to evaluate which advertising is in his best interests, and

Whereas, cigarette advertising constitutes a sizeable percentage of the commercials seen via the television, and

Whereas, our medical profession recognizes the grave dangers in cigarette smoking, as the increase in lung cancer, cardiorespiratory illnesses, etc., as outlined by the United States Public Health Services, gives firm testimony, therefore be it

RESOLVED: That MSMS take the initiative in condemning all cigarette advertising on television, and be it further

RESOLVED: That this resolution be brought to the attention of the United States Public Health Services, the Department of Health, Education and Welfare, and to the legislative body of the American Medical Association, thus creating an awareness of this problem, and hopefully may initiate further action.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read:

"RESOLVED: That MSMS condemn all cigarette advertising on television, and be it further

"RESOLVED: That this resolution be brought to the attention of the United States Public Health Services, the Department of Health, Education and Welfare, and to the legislative body of the American Medical Association, thus creating an awareness of this problem, which hopefully may initiate further action."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 59

Nursing Education

Introduced by Victor Notier, MD

Whereas, there is a serious shortage of nursing personnel, nationwide and particularly in the State of Michigan, and

Whereas, degree bearing nurses are in particular shortage to staff school faculties, and

Whereas, an increasing number of potential applicants to schools of nursing desire a degree granting program, and

Whereas, such programs are of necessity, possible only in cooperation with, and as a part of a duly constituted college authorized to grant a Bachelor's degree, and

Whereas, to plan such new schools involves several years in preparation, therefore be it

RESOLVED: That the State Board of Education be enjoined to authorize such planning, and to officially accredit such schools, as part of the total academic program of such state colleges or universities, that at present do not have such schools, and who are so located that such schools could be developed, and be it further

RESOLVED: That the Legislature be appraised of the critical need in this area and enjoined to take appropriate steps legislatively to facilitate the earliest possible development of such schools as part of state colleges and universities where possible, and be it further

RESOLVED: That early attention be given to the critical needs in the Saginaw-Midland-Bay City area, with the Saginaw Valley College potential, and the Grand Rapids Metropolitan area with the Grand Valley College potential.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered Resolutions 57 and 59 together.

For Reference Committee and House action, see Resolution 57.

RESOLUTION 60

MDPAC

Introduced by Roy J. Gerard, MD

Whereas, MDPAC has functioned as an independent, autonomous organization with the full support of MSMS and its membership, and

Whereas, the need for more and continued political activity with its concomitant financial expenses and expenditures persists and expands, and

Whereas, the AMA and AMPAC, and each state medical society and its PAC have similar relationships and problems, therefore be it

RESOLVED: That The Council of MSMS appoint an ad hoc committee to study the relationships between the various state political action committees and the State Medical Society, and the relationship of the AMA and its PAC-AMPAC, and be it further

RESOLVED: That such an ad hoc committee present its findings and recommendations to The Council and to MDPAC.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution, after amending the first Resolved to read: "That The Council of MSMS appoint an ad hoc committee to study the relationships between the various state medical political action committees and their respective state medical societies, and the relationship of the AMA and AMPAC, and be it further . . ."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 61

Hospital Recertification Forms for Medicare and Medicaid

Introduced by R. J. Toteff, MD

Whereas, considerable time, effort, and money is now being expended by hospital, hospital personnel, and physicians to complete and correct hospital recertification forms for Medicare and Medicaid patients, and

Whereas, this is a "post hoc" type of procedure, since most of these patients have been discharged and accounts paid, and

Whereas, this bureaucratic excuse in boondoggling takes time and effort of medical, paramedical and secretarial personnel which would be more wisely spent in current needs on care, and

Whereas, this certification requires falsification of dates and other data which is immoral and dishonest, even if it is directed by government bureaucracy, and

Whereas, this "post hoc" certification is apparently a punitive bureaucratic exercise done under pressures toward the hospitals which has characteristics of blackmail, and

Whereas, the expense of this procedure causes an increase in cost of medical and hospital care, which is purely due to governmental bureaucracy, and for which the medical profession will be blamed, and

Whereas, by resistance and pressure, the initial certification form was discontinued, it indicates pressure can be successful, therefore be it

RESOLVED: That the House of Delegates of the MSMS recommend that all members of the Society be advised not to sign certification and recertification forms for hospitalization of Medicare and Medicaid patients after January 1, 1969 as already having been demonstrated as being unnecessary, and be it further

RESOLVED: That notification of this action be sent to the Michigan Hospital Service, Michigan Hospital Association, the Michigan State Social Service Board or Commission, The U.S. Social Security System, the AMA, and all other states societies, and be it further

RESOLVED: That this whole "post hoc" bureaucratic boondoggle be documented and sent to all our Michigan Senators and Representatives in the Congress of the United States.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, considered Resolutions 1 and 61 together. For Reference Committee and House action, see Resolution 1.

RESOLUTION 62

Auto Safety

Introduced by Kornelius Van Goor, MD

Whereas, the highway auto injury and death toll continues at an unreduced rate and is one of our major health hazards, and

Whereas, the 1968 Labor Day highway death toll was the greatest ever, and

Whereas, our federal government has misdirected attention to auto defects as an important cause of the highway slaughter, and

Whereas, our state government has made a start toward control of the drinking driver, and

Whereas, the medical profession is concerned with the treatment of the injured and the diseased, but also **more importantly** with the **prevention** of disease and injury, therefore be it

RESOLVED: That MSMS encourage the enactment of legislation which will:

1. More strictly enforce the existing laws relative to driving while drunk and impose more severe penalties for violation thereof.
2. Detect and prosecute the reckless or careless driver.
3. Provide for a more careful and appropriate interval examination of all drivers; and somehow accomplish legislation which will require physicians to report diseases or defects which might affect driving capability to our State Department with the direct result that reevaluation of the driver may be accomplished.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution with the following amendments: Delete the third Whereas, and amend No. 3 in the resolved portion to read, "Provide for a more careful and appropriate interval examination of all drivers."

The Reference Committee also reaffirmed 1967 House of Delegates Resolution 51 on this subject.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 63

Direct Billing of Medicaid Group II (Medically Indigent) Patients

Introduced by Thomas Andrews, MD

Whereas, to preserve the direct patient-doctor payment relationship as the government plans future inclusion of increasingly large groups of employed patients in the medically indigent group, and

Whereas, many physicians want to maintain a direct financial relationship with their patient because they believe that the patient who has some responsibility in the payment mechanism, also may better recognize his responsibility to follow professional advice, and therefore benefit from medical care, and

Whereas, the Federal Title XIX Law provides direct payment to Medicaid Group II Patients at the option of the states; and that the State of Michigan does not now permit direct payment, therefore be it

RESOLVED: That the House of Delegates advise the State Department of Social Services to provide direct payment to Medicaid Group II Patients (Medically Indigent).

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, amended the Resolved portion by adding at the end the words, "through legislative action if needed", and recommended its adoption as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 64

MDPAC

Introduced by Robert E. Rice, MD

Whereas, MDPAC is a voluntary, non-profit, unincorporated committee of individual physicians and others, and

Whereas, MDPAC has demonstrated its ability to encourage better candidates to seek and assist them to obtain office, and

Whereas, health legislation on a local, state and federal level continues to flood the deliberative halls and in an ever increasing tide, therefore be it

RESOLVED: That this House of Delegates commend the MDPAC Board of Directors for its efforts and many successes, and be it further

RESOLVED: That The Council be encouraged to actively support not only MDPAC but deserving local, state and national candidates as well.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 65

"Where We Stand"

Introduced by Harry A. Towsley, MD

Whereas, the monograph "Where We Stand" has been issued to the Delegates and officers of this Society, for two consecutive years, for their perusal and study, and

Whereas, the material therein has been provocative and stimulating in initiating constructive dialogue, and

Whereas, such a summarization of "medical positions" is necessary to our present and future deliberations, therefore be it

RESOLVED: That we commend the author, Mr. Hugh Brenneman, for this labor, and be it further

RESOLVED: That the House of Delegates authorize a yearly revision and updating of this monograph.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 66

Commendation to Claude L. Weston, MD

Introduced by James B. Blodgett, MD

Whereas, this House of Delegates of the Michigan State Medical Society is now convened in its 103rd Annual Session, and

Whereas, members of the House of Delegates, in accepting the responsibility of representing their constituent fellow physicians therein, perform a vital service to their Society and all of its individual members, and

Whereas, by giving of themselves, their valuable time and energies, delegates participate in the shaping of the course of our State Medical Society to the ultimate benefit of the profession and the people of Michigan it serves, and

Whereas, for nearly a full fourth of the 103 Annual Sessions of MSMS, without interruption, one delegate has faithfully and effectively represented his county medical society, making thereby a highly unusual and outstanding contribution to both his colleagues and the Society as a whole; therefore be it

RESOLVED: That this House of Delegates here and now, in deep appreciation and admiration, by rising acclamation, adopt this resolution commending and thanking Claude L. Weston, MD, delegate from Shiawassee County Medical Society, for his 26 consecutive years of service to this House of Delegates, his county society, the profession of medicine and the people of Michigan.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 67

Confidentiality of Michigan Medical Service Records

Introduced by Donald N. Sweeny, Jr., MD

Whereas, in the administration of Medicare, Michigan Blue Shield develops data and material relating not only to Part B of Medicare but also to other aspects of Blue Shield activity, and

Whereas, physicians' profiles and the data upon which they are based are illustrative of such composite data, and

Whereas, such data is received by Blue Shield from Michigan physicians in a confidential capacity; therefore be it

RESOLVED: That Blue Shield be urged to resist to the extent of its ability any effort by the Secretary of HEW to assert ownership of such data, and be it further

RESOLVED: That a copy of this resolution be transmitted to the Board of Trustees, American Medical Association and to the presidents of each state or territorial association for reference to his AMA Delegation.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 68

University of Michigan Hospital Centennial — 1969

Introduced by Harold F. Falls, MD

Whereas, the year 1969 will commemorate the one hundredth year of operation of the University Hospital of the University of Michigan Medical School, and

Whereas, the University Hospital has gained national and international recognition for its many contributions to medical science, organized medicine, medical education and services to patients of the State of Michigan and the Nation, and

Whereas, the University Hospital of the University of Michigan was the first of state-owned university hospitals to serve the patients and the doctors of any state in this Nation, and

Whereas, the University Hospital was recently recognized as one of the ten leading hospitals in the Nation, therefore be it

RESOLVED: That this House of Delegates to the MSMS extend its congratulations to the Board of Regents of the University of Michigan, to the past and current staff and administrative officers of the University Hospital for its past attainments and services to the people of the State of Michigan, and be it further

RESOLVED: That this House of Delegates, and MSMS extend its best wishes for the continuation of its outstanding service to the people of Michigan, and be it further

RESOLVED: That a copy of this commendation be sent to the officials of the University of Michigan.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 69

Advantages of Medical Practice in Michigan

Introduced by R. C. Prophater, MD

Whereas, there is a shortage of physicians in private practice in Michigan, and

Whereas, many more of the graduates of Michigan medical schools undoubtedly would decide to engage in private practice in Michigan if adequately informed of the opportunities available in this state; therefore be it

RESOLVED: That the Michigan State Medical Society encourage the various community agencies, such as chambers of commerce, to inform the students of the three Michigan medical schools of the advantages of medical practice in their areas.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration and adopted the resolution.

SPECIAL MEMBERSHIPS

THE REFERENCE COMMITTEE on Special Memberships, Arthur B. Levant, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the Secretary of MSMS in accordance with the Bylaws:

Life Memberships

Bay-Arenac-Iosco County — W. G. Gamble, Jr., MD; Otto F. Jens, MD; Mana Kessler, MD; Sabina Kessler-Frux, MD.

Calhoun County — John Robbert, MD.

Genesee County — James K. Sutherland, MD.

Ingham County — A. Edith Hall Kent, MD; Herbert K. Kent, MD; Milton Shaw, MD; Howard S. Willson, MD.

Jackson County — Ennis H. Corley, MD.

Kalamazoo County — William D. Irwin, MD; Alton E. Pullon, MD.

Kent County — Cornetta G. Moen, MD; William F. Reus, MD; Harold E. Veldman, MD.

Luce County — T. W. Thompson, MD.

Marquette-Alger County — Arthur L. Amolsch, MD.

Monroe County — Leonard C. Blakey, MD.

Oakland County — Ernest W. Bauer, MD; Ethel T. Calhoun, MD; Carl W. Dahlgren, MD; Loren C. Sheffield, MD; Loren C. Spademan, MD.

Ottawa County — Dirk C. Bloemendaal, MD; W. C. Kools, MD; Ralph Ten Have, MD.

Saginaw County — Suel A. Sheldon, MD; V. K. Volk, MD; Stuart Yntema, MD.

St. Clair County — John C. S. Battley, MD; J. Gilmore Kirker, MD.

Washtenaw County — Arthur C. Curtis, MD; Reed M. Nesbit, MD; Henry K. Ransom, MD; James L. Wilson, MD.

Wayne County — Harry E. August, MD; Louis L. Barnett, MD; A. Robert Bauer, MD; J. Keaner Bell, MD; Robert H. Berman, MD; John H. Boyd, MD; Harry L. Buller, MD; Howard A. Burrows, MD; Volney N. Butler, MD; Henry G. Chall, MD; Esther H. Dale, MD; Robert Durham, MD; Robert J. Elvidge, MD; Harold B. Fenech, MD; Russell F. Fenton, MD; Henry C. Galantowicz, MD; Ely W. Harelik, MD; Thomas J. Jamieson, MD; Stanley J. Joyce, MD; Raymond H. Koebel, MD; Maurice J. Kritchman, MD; Francis X. Krynicki, MD; J. Hugh Lewis, MD; J. Donald Mabley, MD; Rupert C. L. Markoe, MD; Pedro O. Martinez, MD; James J. McClendon, MD; Clarke M. McColl, MD; Clarence D. Moll, MD; Eugene A. Osius, MD; Harry A. Pearse, MD; Abraham S. Rogoff, MD; Frank M. Townsend, MD; Albert E. Vossler, MD; George L. Waldbott, MD; Edward A. Wishropp, MD; Wilford C. Wood, MD.

Retired Memberships

Allegan County — Lewis F. Brown, MD.

Bay-Arenac-Iosco County — Leslie A. Lambert, MD; Michael Medvesky, MD.

Calhoun County — Norman H. Amos, MD; Richard J. Campbell, MD; Stephen Fairbanks, MD.

Cass County — Rudolph I. Clary, MD.

Delta-Schoolcraft County — A. B. Bernier, MD.

Gratiot-Isabella-Clare County — William L. Harrigan, MD.

Ingham County — Roger Hanna, MD; Paul J. Ochsner, MD; Ralph H. Ruhnkorff, MD; Ralph Wadley, MD.

Kalamazoo County — Frederick M. Doyle, MD; Paul M. Fuller, MD; Robert C. Murdy, MD.

Kent County — Leon DeVel, MD.

Midland County — Harold H. Gay, MD.

Oakland County — Henry O. Coucke, MD; James T. Cheng, MD; Aben Hoekman, MD; Oliver Marcotte, MD; Theodore H. Pauli, MD.

Oceana County — Merle G. Wood, MD.

Saginaw County — Gerald L. Ackerman, MD; Harry M. Bishop, MD; Francis V. Kowals, MD; Harry G. Richter, MD.

Tuscola County — Willard W. Dickerson, MD.

Washtenaw County — Philip N. Brown, MD.

Wayne County — Leslie T. Colvin, MD; Charles C. Eades, MD; Harold H. Harris, MD; Paul V. O'Rourke, MD; Meshel Rice, MD.

Associate Memberships

The list of candidates for Associate Membership from Washtenaw County was reviewed. Since all candidates are eligible, no action is required by the House of Delegates inasmuch as they may become Associate Members of this Society upon application and certification by the secretary of their component medical society.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

CERTIFICATES OF COMMENDATION

Speaker James B. Blodgett, MD, presented the following Certificates of Commendation as authorized by the House of Delegates:

A. Fleming Barbour, MD, Genesee County —

"In recognition of his inspiring civic service in Flint for more than 25 years, especially with community programs for children, churches, the needy; and also for his excellent leadership in medical and specialty organizations."

Harry A. Clark, MD, Mason County —

"In recognition of many years of inspirational teaching as a professor at the Wayne State University Medical School; and in appreciation for continuing medical contributions to the people of Muskegon, and now Mason counties."

John M. Dorsey, MD, Wayne County —

"In recognition of his distinguished career as a psychiatrist, teacher and chairman of the Wayne State University Medical School Department of Psychiatry; and his many continuing contributions now to medicine, literature and education as the 'WSU University Professor,' "

Fred C. Sabin, MD, Marquette-Alger County —

"In recognition of his dedicated service as a member of the Northern Michigan University Board of Control and as a member of the Michigan State Board of Registration in Medicine; and as a prominent citizen of Marquette in professional, political and business circles."

Wilbur D. Towsley, MD, Midland County —

"In recognition of 45 years of distinguished service in Midland as a beloved family doctor; and for his unselfish assistance to many medical students, and also to many children and families in need."

MICHIGAN'S OUTSTANDING PHYSICIAN

James B. Blodgett, MD, Speaker, presented to Marjorie Peebles Meyers, MD, of Detroit, the following award as Michigan's Outstanding Physician of 1968:

"In recognition of a distinguished career as a Detroit internist, as an excellent clinical instructor for the Wayne State University Medical School, as a medical statesman for the Wayne County Medical Society and Michigan State Medical Society, and as a member of the Michigan delegation to the AMA House of Delegates; and also in recognition of inspiring service and leadership with many Michigan and Detroit health, welfare, cultural and educational organizations."

FIFTY YEAR AWARDS

President Bradley M. Harris, MD, presented the Fifty Year Award to the following:

Elden C. Baumgarten, MD, Wayne County
A. M. Giddings, MD, Calhoun County
Lloyd C. Harvie, MD, Saginaw County
Clyde K. Hasley, MD, Wayne County
M. S. Hurth, MD, Ingham County
Karm C. Kerwell, MD, Menominee County
Fred O. Lepley, MD, Wayne County
Milton D. Vokes, MD, Wayne County
Alfred H. Whittaker, MD, Wayne County

Fifty Year Awards subsequently were presented to the following persons who were not able to be present:

Wyman C. C. Cole, Sr., MD, Wayne County
Ray S. Dixon, MD, Wayne County
William E. Hilton, MD, Wayne County
Joseph A. Kasper, MD, Wayne County
Sol M. Lewis, MD, Oakland County
Welcome B. Lewis, MD, Calhoun County
Alton R. Marsh, MD, Wayne County
Arthur B. Norton, MD, Wayne County
Robert L. Novy, MD, Wayne County
Harold F. Raynor, MD, Wayne County
John B. Rieger, MD, Wayne County
Isaac S. Schembeck, MD, Wayne County
Edward F. Sladek, MD, Grand Traverse, Leelanau-Benzie County
James M. Stanton, MD, Wayne County
Garnet G. Stonehouse, MD, Kent County
William V. VanderVoort, MD, Calhoun County
T. P. Wickliffe, MD, now in Escondido, California

PRESIDENT'S AWARDS

President Bradley M. Harris, MD, presented awards "in recognition of and grateful appreciation for distinguished service to medicine" to:

Edwin DeYoung, MD, Birmingham — President, American Academy of Occupational Medicine

Francis P. Rhoades, MD, Detroit — President, Academy of Psychosomatic Medicine

John Hanlon, MD, Detroit — President, American Public Health Officers Association

SPECIAL AWARDS

The following AMA Certificates of Humanitarian Service were presented by AMA President-Elect Gerald D. Dorman, MD, to:

Daniel D. Chapman, MD, Owosso
J. Colin Elliott, MD, Buchanan
Joseph A. Grady, MD, Detroit
Seymour Krevsky, MD, Detroit
Armand M. LaSorsa, MD, Manistique
Donald Lipsey, MD, Durand
Adrian J. Neerken, MD, Kalamazoo
Leonard M. Pickering, MD, Southgate
Henry C. Scharnweber, MD, Midland
Roger A. Scholten, MD, Kalamazoo
Daniel B. White, MD, Rochester

"Presented by the American Medical Association in recognition of the meritorious service performed for the medical profession, the United States Government and the people of South Viet Nam by treating the ill and injured during his medical mission under the AMA's Volunteer Physicians for Viet Nam."

Speaker James B. Blodgett, MD, presented a Past Speaker's Key to former Speaker James J. Lightbody, MD.

EMPLOYEE AWARDS

Council Chairman Robert J. Mason, MD, presented the following employee awards as previously authorized by the House of Delegates:

Helen A. Schulte — 25 years of service
Robert J. Roney — 20 years of service

TRIBUTE TO DECEASED FORMER MEMBERS OF THE HOUSE OF DELEGATES

Secretary Kenneth H. Johnson, MD, read the following names and the members of the House arose and stood in silent tribute to their memory:

Charles L. Hess, MD, Bay County
Donald R. Wright, MD, Genesee County
I. W. Brown, MD, Kalamazoo County
J. R. McBride, MD, Lapeer County
H. D. Dykhuizen, MD, Muskegon County

C. T. Ekelund, MD, Oakland County
Oliver W. Lohr, MD, Saginaw County
Harry F. Dibble, MD, Wayne County
Crosby D. Eaton, MD, Wayne County
Joseph Hickey, MD, Wayne County

ELECTIONS

The following Officers and Councilors were elected:

President-Elect — Robert J. Mason, MD, Birmingham
Speaker — James B. Blodgett, MD, Detroit
Vice-Speaker — Vernon V. Bass, MD, Saginaw
Councilors (3-year terms) —
1st District: Milton R. Weed, MD, Grosse Pointe Park
7th District: John J. Coury, MD, Port Huron
8th District: A. Carl Stander, MD, Saginaw
10th District: Edward H. Rodda, MD, Bay City
12th District: William A. LeMire, MD, Escanaba
15th District: Sydney Scher, MD, Mount Clemens

Delegates to the American Medical Association
(January 1, 1969, to December 31, 1970)
Sidney Adler, MD, Detroit
George W. Slagle, MD, Battle Creek
Donald N. Sweeny, Jr., Detroit
Joseph A. Witter, MD, Highland Park

Alternate Delegates to the American Medical Association

(January 1, 1969, to December 31, 1970)
(in order of seniority)

James C. Danforth, Jr., MD, Detroit
Marjorie Peebles Meyers, MD, Detroit
John J. Coury, MD, Port Huron
Vernon V. Bass, MD, Saginaw

DIRECTORY

1968 MSMS House of Delegates

RECORD OF ATTENDANCE

OFFICERS

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Speaker:						
James B. Blodgett, MD, Detroit	X	X	X	X	X	X
Vice Speaker:						
Vernon V. Bass, MD, Saginaw	X	X	X	X	X	X
Immediate Past President:						
C. Allen Payne, MD, Grand Rapids	—	X	—	—	—	—
Secretary:						
Kenneth H. Johnson, MD, Lansing	X	X	X	X	X	X

DELEGATES

	Meetings					
	1st	2nd	3rd	4th	5th	6th
ALLEGAN						
Gerald A. VanderVoord, MD, Wayland	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE						
Frederick C. O'Dell, MD, Alpena	X	X	—	X	X	X
BARRY						
Robert J. Huebner, MD, Hastings	X	X	X	X	—	X
BAY-ARENAC-IOSCO						
Howard T. Knobloch, MD, Bay City	X	X	X	X	X	X
Robert C. Prophater, MD, Bay City	X	X	X	X	X	X
BERRIEN						
F. Alan Kennedy, MD, Benton Harbor	X	X	X	X	X	X
Frederick H. Lindenfeld, MD, Niles	—	X	X	X	X	X
BRANCH						
Robert M Leitch, MD, Union City; and	X	—	X	X	X	X
John D. Rick, MD, Coldwater	—	X	—	—	—	—
CALHOUN						
George T. Kelleher, MD, Battle Creek	X	X	X	X	X	X
Russell C. Rowan, MD, Albion	X	X	—	X	X	X
CASS						
Lowell D. Smith, MD, Cassopolis	—	—	—	X	X	X
CHIPPEWA-MACKINAC						
Donald D. Finlayson, MD, Sault Ste. Marie	X	X	X	X	X	X
CLINTON						
James M. Grost, MD, St. Johns	X	X	X	X	X	X
DELTA-SCHOOLCRAFT						
Donald N. Fitch, MD, Escanaba	X	X	X	X	X	X
DICKINSON-IRON						
Donald T. Anderson, MD, Kingsford	X	X	X	—	—	—
EATON						
Clayton O. Willits, MD, Charlotte	X	X	X	X	X	X
GENESEE						
John C. Benson, MD, Flint	—	—	X	X	X	X
Clifford W. Colwell, MD, Flint	X	X	X	X	X	—
Ernest P. Griffin, Jr., MD, Flint	X	X	X	X	X	X
Richard J. McMurray, MD, Flint	X	X	X	X	X	X
Lewis E. Simoni, MD, Flint	X	X	X	X	X	X
Philip K. Stevens, MD, Flint	X	X	X	X	X	X
Charles A. Thompson, MD, Flint	X	X	X	X	X	X
GOGEBIC						
Not represented						
GRAND TRAVERSE-LEELANAU-BENZIE						
Arthur F. Dundon, MD, Traverse City	X	X	X	X	—	—
Frank H. Power, MD, Traverse City	X	X	X	X	—	—
GRATIOT-ISABELLA-CLARE						
John M. Wood, MD, Mt. Pleasant	X	—	X	X	X	X
HILLSDALE						
Clark B. Smith, MD, Hillsdale	X	X	X	X	X	X
HOUGHTON-BARAGA-KEWEENAW						
Kenneth E. Rowe, MD, Calumet	X	X	X	X	X	X
HURON						
Charles W. Oakes, Jr., Harbor Beach	X	X	X	X	X	X
INGHAM						
Joseph R. Cipparone, MD, Lansing; and	X	X	X	X	—	—
John G. Wiegenstein, MD, Lansing	—	—	—	—	—	X
Herbert W. Harris, MD, Lansing	X	X	X	X	X	X
D. Bonta Hiscoe, MD, Lansing	X	X	X	X	X	X
Charles O. Long, Jr., MD, Lansing	X	X	X	X	X	X
Justin L. Sleight, MD, Lansing	X	X	X	X	X	—
Robert M. Stow, MD, Lansing	X	X	X	X	X	X
IONIA-MONTCALM						
Robert E. Rice, MD, Greenville	X	X	—	—	X	X
JACKSON						
Francis P. McQuillan, MD, Jackson	X	X	X	X	X	X
Harold L. Oster, MD, Jackson	X	X	X	X	X	X
KALAMAZOO						
Thomas E. Andrews, MD, Jackson	X	X	X	X	X	X
William D. Harrelson, MD, Kalamazoo	X	X	X	X	—	—
W. Kaye Locklin, MD, Kalamazoo	X	X	X	X	X	X
A John Neerken, MD, Kalamazoo	—	X	X	X	—	—
KENT						
Harvey M. Andre, MD, Grand Rapids	X	X	X	X	X	X
Noyes L. Avery, MD, Grand Rapids	X	X	X	X	X	—
Fred C. Brace, MD, Grand Rapids	X	X	X	X	X	X
Frederick S. Gillett, MD, Grand Rapids	X	X	—	X	X	X
William Haeck, Jr., MD, Grand Rapids	X	X	X	X	X	X
Jack Hoogerhyde, MD, Grand Rapids	X	X	X	X	X	X
Victor A. Notier, MD, Grand Rapids	X	X	X	X	X	X
Kornelius Van Goor, MD, Grand Rapids	X	X	X	X	X	X
LAPEER						
Charles E. Conaway, MD, Lapeer	X	X	X	X	X	X
LENAWEE						
Donato F. Sarapo, MD, Adrian	X	X	X	X	X	X
LIVINGSTON						
Edwin S. Woodworth, MD, Howell	—	X	—	X	X	X
LUCE						
Bernard G. Keizer, MD, Newberry	—	—	—	—	X	X
MACOMB						
Charles M. Ebner, MD, St. Clair Shores	X	X	X	X	X	X
Peter V. Kane, MD, Mt. Clemens	X	X	X	X	X	X
Sydney Scher, MD, Mt. Clemens	X	X	X	X	X	X
Edward G. Siegfried, MD, Mt. Clemens	X	X	X	X	X	X
MANISTEE						
Donald N. Schwing, MD, Manistee	—	—	X	—	—	—
MARQUETTE-ALGER						
George M. Wilson, Jr., MD, Marquette	X	X	X	X	X	X
MASON						
William F Sutter, MD, Ludington	X	X	X	X	—	—
MECOSTA-OSCEOLA-LAKE						
James L. Tyson, MD, Big Rapids	X	X	X	X	X	X
MENOMINEE						
Herman R. Brukardt, MD, Menominee	X	X	X	X	X	X
MIDLAND						
V. A. Marks, MD, Midland	X	X	X	X	X	X
MONROE						
S. Newton Kelso, Jr., MD, Monroe	X	X	X	X	X	X
MUSKEGON						
Howard V. Sanden, MD, Muskegon; and	X	X	X	—	—	—
Robert Swedenburg, MD, Muskegon	—	—	—	X	X	X
Norbert W. Scholle, MD, Muskegon	X	X	—	X	X	X
Donald P. Stratton, MD, Muskegon	X	X	X	X	X	X
NEWAYGO						
J. Paul Klein, MD, Fremont	X	X	—	X	X	X
NORTH CENTRAL						
Charles L. Oppy, MD, Roscommon	X	X	X	X	X	X
NORTHERN MICHIGAN						
Not represented						
OAKLAND						
Bruce D. Bauer, MD, Berkley	X	X	X	X	X	X
Robert M. Bookmyer, MD, Birmingham	X	—	—	—	—	—
Arnold L. Brown, MD, Pontiac	X	X	X	X	X	X
Peter A. Duhamel, MD, Rochester	—	X	X	X	X	—
Edward E. Elder, Jr., MD, Pontiac	X	X	X	X	X	X
Harold A. Furlong, MD, Pontiac	X	X	X	X	X	X
Richard R. Galpin, MD, Birmingham	X	X	X	X	X	—

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Worth W. Henderson, MD, Royal Oak	—	—	X	X	X	X
Paul T Lahti, MD, Royal Oak	X	X	X	X	X	X
John H. McLaughlin, MD, Birmingham	X	X	X	X	X	X
James R. Quinn, Jr., MD, Pontiac	X	X	—	X	X	X
James A. Read, MD, Birmingham	—	X	X	X	X	X
F. Michael Sheridan, MD, Royal Oak	X	X	—	X	X	X
OCEANA						
John J. Vrbanac MD, Hart	—	X	X	X	X	X
ONTONAGON						
Not represented						
OTTAWA						
William Rottschaefer, MD, Holland	X	X	X	X	X	X
SAGINAW						
Jack L. Barry, MD, Saginaw	—	X	X	X	X	X
Roy J. Gerard, MD, Saginaw	X	X	—	X	X	X
Duane B. Heilbronn, MD, Saginaw	X	X	X	X	X	X
Robert J. Toteff, MD, Saginaw; and	X	X	—	X	X	X
William A. DeYoung, MD, Saginaw	—	—	X	—	—	—
ST. CLAIR						
Alexander E. Hlivko, MD, St. Clair	X	X	X	X	—	—
James H. Tisdel, MD, Port Huron	X	X	X	X	X	—
ST. JOSEPH						
Stanley C. Penzotti, MD, Three Rivers	X	X	X	X	X	X
SANILAC						
Keate T. McGunegle, MD, Sandusky	X	X	X	X	X	X
SHIAWASSEE						
Claude L. Weston, MD, Owosso	X	X	X	X	X	X
TUSCOLA						
Herbert Lee Nigg, MD, Caro	X	X	X	X	X	X
VAN BUREN						
David J. Millard, MD, Paw Paw	X	X	X	X	X	X
WASHTENAW						
Clarence E. Crook, MD, Ann Arbor	X	X	X	X	—	X
Stuart M. Gould, Jr., MD, Ann Arbor	X	X	X	X	X	X
John W. Henderson, MD, Ann Arbor	X	X	X	X	X	X
John E. Magielski, MD, Ann Arbor; and	X	X	X	X	—	—
Robert S. Ideson, II, MD, Ann Arbor	—	—	—	—	—	X
Beverly C Payne, MD, Ann Arbor	X	X	X	X	X	X
Henry A. Scovill, MD, Ypsilanti	X	X	X	X	X	X
Harry A. Towsley, MD, Ann Arbor	X	X	X	X	X	X
Howard R. Williams, MD, Ann Arbor	X	X	X	X	X	X
WAYNE						
Sidney Adler, MD, Detroit	—	X	X	X	—	—
Robert D. Allaben, MD, Detroit	X	X	X	X	X	X
Raymond J. Barrett, MD, Detroit	X	—	X	—	—	—
Frank B. Bicknell, MD Detroit	—	—	X	—	—	—
Alexander Blain, III, MD, Detroit	X	X	X	X	—	—
James B. Blodgett, MD, Detroit	—	—	—	—	—	—
William L. Brosius, MD, Rochester	X	X	X	X	X	X
Brock E. Brush, MD, Detroit	X	X	X	X	X	X
Fred E. Caumartin, MD, Detroit	X	X	X	X	X	X
Ned I. Chalat, MD, Detroit	—	—	X	X	X	X
Sidney E. Chapin, MD, Dearborn	X	X	X	X	X	X
Paul J. Connolly, MD, Detroit	X	X	X	X	X	X
James C. Danforth, Jr., MD, Grosse Pte. Wds.	X	X	X	X	X	X
Charles E. Darling, MD, Detroit	—	X	X	X	X	X
Henry M. Domzalski, MD, Detroit	X	X	X	X	X	X
Paul R Dumke, MD, Detroit	X	X	X	X	X	X
Laurel S. Eno, MD, Detroit	X	X	X	X	X	X
George S. Fisher, MD, Detroit	X	X	X	X	X	X
Thomas M. Flake, MD, Detroit	X	X	X	X	X	X
C. Jackson France, MD, Detroit	X	X	X	X	X	X
Eugene L. Freitas, MD, Detroit	X	X	X	X	X	X
James D. Fryfogle, MD, Southfield	X	X	X	X	X	X
Thomas Ganos, MD, Allen Park	—	—	X	X	X	X
Alfred Golden, MD, Huntington Woods	X	X	X	—	—	—
Robert H. Hamburg, MD, Detroit	X	X	—	—	—	—
Louis E. Heideman, MD, Detroit	—	—	—	X	X	X
Alexander H. Hirschfeld, MD, Detroit; and	X	X	X	X	—	X
Robert B. Clarke, MD, Detroit	—	—	—	—	X	—
Homer A. Howes, MD, Detroit	X	X	X	X	X	X
H. Ross Hume, MD, Detroit	X	X	X	X	X	X
Eli J. Igna, MD, Detroit	X	X	X	X	X	X
Benjamin Jeffries, MD, Harper Woods	X	X	—	X	X	X
Loyal W. Jodar, MD, Grosse Pte.	X	X	X	—	—	—
Harry Y. Kasabach, MD, Detroit	X	X	X	X	X	X
James M. Kennary, MD, Detroit	X	X	X	X	X	X
Luther R. Leader, MD, Royal Oak	X	X	X	X	X	—
Arthur B. Levant, MD, Detroit	X	X	X	X	X	X
Robert E. McKnight, MD, Southfield	—	—	—	—	—	—
Marjorie Peebles Meyers, MD, Detroit	X	X	X	X	—	—
Harold V Morley, MD, Detroit	X	X	X	X	X	X
John W. Moses, MD, Detroit	X	X	X	X	X	X
John W. Moynihan, MD, Dearborn	—	—	X	—	—	—
Ralph H. Pino, MD, Plymouth	X	X	X	X	X	X
George L. Reno, MD, Detroit	X	X	X	X	X	X
Francis P. Rhoades, MD, Detroit	X	X	X	X	X	X
John W. Sigler, MD, Detroit	X	X	X	X	X	X
John G. Slevin, MD, Grosse Pte. Park	X	X	X	X	X	X
Homer M. Smathers, MD, Detroit	X	X	X	X	X	X

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Carl J. Sprunk, MD, Melvindale	X	—	X	—	X	X
Donald N. Sweeny, Jr., MD, Detroit	X	X	X	X	X	X
Edward J. Tallant, MD, Detroit	X	X	X	X	X	X
Frank B. Walker, MD, Grosse Pte. Park	X	X	X	X	X	X
Frederick Weissman, MD, Southfield	—	—	X	—	—	—
Alfred H. Whittaker, MD, Grosse Pointe; and	X	—	—	—	—	—
Earl C. Long, MD, Detroit	—	—	—	—	—	X
Joseph A. Witter, MD, Highland Park	X	X	X	X	X	X
William J. Yott, MD, Detroit	X	X	X	X	X	X
Louis R. Zako, MD, Allen Park	—	—	—	—	—	—
WEXFORD-MISSAUKEE						
Dennis E. Van Alst, MD, Cadillac	X	X	X	X	X	X
SECTION DELEGATES						
ALLERGY AND APPLIED IMMUNOLOGY						
James A McLean, MD, Ann Arbor	X	X	X	—	—	—
ANESTHESIOLOGY						
Ralph F. Askam, MD, Muskegon	—	X	X	X	X	X
DERTAMOLOGY						
Robert J. Schoenfeld, MD, Birmingham	X	—	X	—	—	—
GASTROENTEROLOGY						
Not represented						
GENERAL PRACTICE						
Douglas A. Haddock, Jr., MD, Kalamazoo	X	X	X	X	X	X
INTERNAL MEDICINE						
Not represented						
NEUROLOGICAL SURGERY						
H. Harvey Gass, MD, Detroit	—	X	X	—	—	—
OBSTETRICS-GYNECOLOGY						
Howard R. Williams, MD, Ann Arbor	—	—	—	—	—	—
OCCUPATIONAL MEDICINE						
Not represented						
OPHTHALMOLOGY						
Not represented						
OTOLARYNGOLOGY						
Not represented						
ORTHOPEDIC SURGERY						
Edward F. Kickham, MD, Saginaw	—	X	—	—	—	—
PATHOLOGY						
John R. McDonald, MD, Detroit	—	—	X	X	X	—
PEDIATRICS						
George L. Blum, MD, Detroit	X	—	—	—	—	—
PHYSICAL MEDICINE						
Not represented						
PLASTIC SURGERY						
Edward J. Hill, Jr., MD, Detroit	—	—	—	—	—	—
PROCTOLOGY						
Donald J. Pearson, MD, Battle Creek	X	X	X	X	X	X
PHYCHIATRY & NEUROLOGY						
Robert B. Clarke, MD, Detroit	X	X	—	—	X	—
PUBLIC HEALTH & PREVENTIVE MEDICINE						
G. Frederick Moench, MD, Sanford	X	X	X	X	X	X
RADIOLOGY						
Benjamin R. VanZwalenburg, MD, Grand Rapids	X	X	X	—	—	—
SURGERY						
John W. Derr, MD, Detroit	X	—	—	—	—	—
THORACIC SURGERY						
Not represented						
UROLOGY						
Robert C. Thumann, MD, Grosse Pte. Woods	X	X	—	X	X	X
MEDICAL STUDENTS						
SAMA						
Rosemarie Lucianin	X	X	X	X	X	—
UNIVERSITY OF MICHIGAN						
Joseph Luciano	X	—	—	—	—	—
Joel Morganroth	X	X	X	—	—	—
Charles Artinian	X	X	X	X	—	—
WAYNE STATE UNIVERSITY						
David Priver	X	X	X	X	X	X
Charles Dumanois	—	X	X	—	—	—

REFERENCE COMMITTEES

CONSTITUTION AND BYLAWS

C. J. France, MD, Chairman, Wayne
J. M. Kennary, MD, Wayne
S. M. Gould, Jr., MD, Washtenaw
D. O. Sarapo, MD, Lenawee
P. K. Stevens, MD, Genesee
D. J. Millard, MD, Van Buren

Councilor Advisors:

J. J. Coury, MD, Port Huron
H. F. Falls, MD, Ann Arbor

CREDENTIALS AND TELLERS COMMITTEE

K. T. McGunegle, MD, Chairman, Sanilac
C. W. Colwell, MD, Genesee
C. W. Oakes, Jr., MD, Huron
A. H. Whittaker, MD, Wayne
J. A. Witter, MD, Wayne
W. J. Yott, MD, Wayne
F. C. O'Dell, MD, Alpena-Alcona-Presque Isle

HEALTH INSURANCE AND MEDICAL SERVICES

R. E. Rice, MD, Chairman, Ionia-Montcalm
F. A. Kennedy, MD, Berrien
C. L. Reno, MD, Wayne
F. P. Rhoades, MD, Wayne
R. J. Toteff, MD, Saginaw
F. S. Gillett, MD, Kent
A. J. Neerken, MD, Kalamazoo

Councilor Advisors:

H. H. Hiscock, MD, Flint
B. L. Masters, MD, Fremont
D. W. McLean, MD, Detroit

MISCELLANEOUS BUSINESS

Marjorie Peebles Meyers, MD, Chairman, Wayne
A. L. Brown, MD, Oakland
G. R. Kelleher, MD, Calhoun
F. C. Brace, MD, Kent
H. L. Oster, MD, Jackson
C. E. Darling, MD, Wayne
C. E. Conaway, MD, Lapeer

Councilor Advisors:

E. R. Elzinga, MD, Marquette
A. C. Stander, MD, Saginaw
J. R. Pedden, MD, Grand Rapids

PUBLIC AND PROFESSIONAL RELATIONS

P. T. Lahti, MD, Chairman, Oakland
E. S. Woodworth, MD, Howell
R. H. Hamburg, MD, Wayne
D. B. Hiscoe, MD, Ingham
E. J. Tallant, MD, Wayne
D. E. Heilbronn, MD, Saginaw

Councilor Advisors:

Don. Marshall, MD, Kalamazoo
E. H. Rodda, MD, Bay City

REPORTS OF COUNCIL AND OFFICERS

E. E. Elder, Jr., MD, Chairman, Oakland
Frank Bicknell, MD, Wayne
H. W. Harris, MD, Ingham
J. C. Danforth, MD, Wayne
William Rottschaefer, MD, Ottawa

Councilor Advisors:

R. F. Mason, MD, Birmingham
R. V. Taylor, MD, Jackson

REPORTS OF STANDING & SPECIAL COMMITTEES

H. A. Towsley, MD, Chairman, Washtenaw
Alexander Blain, III, MD, Wayne
B. E. Brush, MD, Wayne
D. D. Finlayson, MD, Chippewa-Mackinac
E. P. Griffin, Jr., MD, Genesee

Councilor Advisors:

Sidney Adler, MD, Detroit
R. V. Daugharty, MD, Cadillac

RESOLUTIONS

R. C. Prophater, MD, Chairman, Bay-Arenac-Iosco
V. A. Marks, MD, Midland
J. G. Slevin, MD, Wayne
H. M. Smathers, MD, Wayne
C. E. Crook, MD, Washtenaw
R. M. Stow, MD, Ingham
R. R. Galpin, MD, Oakland
P. V. Kane, MD, Macomb

Councilor Advisors:

M. R. Weed, MD, Detroit
J. R. Franck, Jr., MD, Wakefield

STATE AND FEDERAL LEGISLATION

J. D. Fryfogle, MD, Chairman, Wayne
N. L. Avery, Jr., MD, Kent
Benjamin Jeffries, MD, Wayne
J. R. Quinn, MD, Oakland
D. T. Anderson, MD, Dickinson-Iron

Councilor Advisors:

R. R. Cooper, MD, Detroit
H. C. Hansen, MD, Battle Creek
B. M. Harris, MD, Ypsilanti

SPECIAL MEMBERSHIPS

Arthur B. Levant, MD, Chairman, Wayne
John M. Wood, MD, Gratiot-Isabella-Clare
B. G. Keizer, MD, Newberry

WAYS AND MEANS

S. N. Kelso, Jr., MD, Chairman, Monroe
W. C. C. Cole, Jr., MD, Wayne
Jack Hoogerhyde, MD, Kent
J. W. Moses, MD, Wayne
F. H. Power, MD, Grand Traverse-Leelanau-Benzie
Sidney Scher, MD, Macomb

Councilor Advisors:

R. K. Whiteley, MD, Detroit
C. A. Payne, MD, Grand Rapids

RULES AND ORDER OF BUSINESS

H. A. Scovill, MD, Chairman, Washtenaw
H. A. Furlong, MD, Oakland
S. C. Penzotti, MD, St. Joseph
G. S. Fisher, MD, Wayne
F. E. Caumartin, MD, Wayne
E. G. Siegfried, MD, Macomb

PARLIAMENTARIAN

Mr. A. Stewart Kerr

DIRECTORY
OF
MEMBERS

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY
VOLUME 67, NUMBER 23
PART TWO NOVEMBER 1968

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Detroit Office: 1010 Antietam, Detroit 48207

American Medical Association
Headquarters: 535 N. Dearborn, Chicago 60610
Washington Office: 1 Farragut Square, South, Washington, D.C. 20006

Michigan Association of Regional Medical Plans, 1111 Michigan, East Lansing 48823
Albert E. Heustis, M.D., Executive Director

Michigan Council on Smoking and Health, 712 Abbott, East Lansing 48823
Ben Yep, Coordinator

Michigan Doctors Political Action Committee
P.O. Box 169, East Lansing 48823

Michigan Foundation for Medical and Health Education
120 West Saginaw, East Lansing 48823

Michigan Health Council, 712 Abbott Rd., East Lansing 48823
John A. Doherty, Executive Director

Michigan Hospital Service (Blue Cross), 441 E. Jefferson, Detroit 48226
Wm. S. McNary, President

Michigan Medical Service (Blue Shield), 441 E. Jefferson, Detroit 48226
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Board of Registration in Medicine, 1033 S. Washington Ave., Lansing 48933
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R. Bernard Houston, Director

MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

Members of the Michigan State Medical Society will find this 1969 issue of the Directory very useful. In addition to the several listings of the MSMS members, the Directory includes valuable reference information about the Michigan State Medical Society and its committees, the American Medical Association, etc.

The Publication Committee of The Council welcomes your suggestions.

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MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

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This Directory lists the membership of each component medical society and therefore the total membership of the Michigan State Medical Society. For more effective reference use, the directory also contains an alphabetical list of all MSMS members, with a reference to both the page number and the county society code number.

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Guide to Help Locate Cities within the Counties

This guide matches up the counties for all Michigan communities of 1,000 population or more.*

CITY and COUNTY

Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Allen Park (Wayne)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)

Bad Axe (Huron)
Bangor (Van Buren)
Battle Creek (Calhoun)
Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)

CITY and COUNTY

Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coloma (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Dearborn Heights, (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)

CITY and COUNTY

Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores
  (Wayne & Macomb)
Grosse Pointe Woods
  (Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

---

*See page 2 for Index by counties.

Guide to Help Locate Cities within the Counties/Continued

CITY and COUNTY

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Lathrup Village (Wayne)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore (Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)
Niles (Berrien)
North Muskegon (Muskegon)

CITY and COUNTY

Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Orchard Lake (Oakland)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmet)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)

CITY and COUNTY

Sandusky (Sanilac)
Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Southfield (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sylvan Lake (Oakland)

Tawas City (Iosco)
Tecumseh (Lenawee)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)

Union City (Branch & Calhoun)
Utica (Macomb)

Vandercook Lake (Jackson)
Van Dyke (Macomb)
Vassar (Tuscola)
Vicksburg (Kalamazoo)

Wakefield (Gogebic)
Walled Lake (Oakland)
Warren (Macomb)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
West Branch (Ogemaw)
Westland (Wayne)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

MICHIGAN STATE MEDICAL SOCIETY

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Detroit Office
1010 Antietam Road, Detroit 48207
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*As of November 1, 1968

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1969—DETROIT, SEPTEMBER 28-OCTOBER 3
1970—DETROIT, SEPTEMBER 20-25
1971—GRAND RAPIDS, OCTOBER 3-8
1972—DETROIT, SEPTEMBER 24-29

MSMS DELEGATES TO AMA

Delegates:

(In alphabetical order according to term of office)

	Term Expires
Otto K. Engelke, M.D., Ann Arbor	12/31/1969
John R. Heidenreich, M.D., Daggett	12/31/1969
Luther R. Leader, M.D., Birmingham	12/31/1969
Robert E. Rice, M.D., Greenville	12/31/1969
Sidney Adler, M.D., Detroit	12/31/1970
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Donald N. Sweeny, Jr., M.D., Detroit	12/31/1970
Joseph A. Witter, M.D., Highland Park	12/31/1970

Alternate Delegates:

(In order of seniority and according to term and according to MSMS Bylaws, Chapter 13, Section 5-[6].)

Paul T. Lahti, M.D., Royal Oak	12/31/69
Harold A. Furlong, M.D., Pontiac	12/31/69
John W. Moses, M.D., Detroit	12/31/69
Bradley M. Harris, M.D., Ypsilanti	12/31/69
James C. Danforth, Jr., M.D., Detroit	12/31/70
Marjorie Peebles-Meyers, M.D., Detroit	12/31/70
John J. Coury, M.D., Port Huron	12/31/70
Vernon V. Bass, M.D., Saginaw	12/31/70

WOMAN'S AUXILIARY TO MSMS

The state officers of the Woman's Auxiliary to the Michigan State Medical Society for the year 1968-69 are:

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Mrs. Earl E. Weston, 5655 Forman Drive, Birmingham 48010

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Mrs. Edward S. Maxim, 34140 Jefferson Avenue, St. Clair Shores 48082

First Vice-President:
Mrs. Francis P. Rhoades, 272 Ashland Avenue, Detroit 48215

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Corresponding Secretary:
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Financial Secretary:
Mrs. George E. McKeever, 45144 Harmony Lane, Belleville 48111

Treasurer:
Mrs. Robert C. Horn, 90 N. Edgewood Drive, Grosse Pointe 48236

STATE MEDICAL ASSISTANTS

The officers of the Michigan State Medical Assistants Society for the year 1968-69 are:

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Mrs. Mary E. Jordan, Community Hospital, Eaton Rapids 48827

President-Elect:
Mrs. Patricia Austin, 216 Michigan Theatre Building, Ann Arbor 48108

Vice-President:
Kay Doane, 710 North Avenue, Battle Creek 49015

Recording Secretary:
Mrs. Betty Boers, 611 Whitcomb, Kalamazoo 49001

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Vice Speaker:
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MSMS Delegates & Alternates
For 1968 MSMS House of Delegates

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L. B. Stevenson, MD, Vice Chairman, Henry Ford Hospital, Detroit 48202

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

D. K. Kessler, MD, Chairman, 540 Belvedere Drive, SE, Grand Rapids 49506

COMMITTEE ON MEDICINE AND OSTEOPATHY

J. J. Coury, MD, Chairman, 1209 Tenth Street, Port Huron 48060

COMMITTEE ON MENTAL HEALTH

Benjamin Jeffries, MD, Chairman, 19959 Vernier Road, Harper Woods 48236

E. H. Rodda, MD, Vice Chairman, 101 W. John Street, Bay City 48706

COMMITTEE ON OCCUPATIONAL HEALTH

William Jend, Jr., MD, Chairman, 1365 Cass Avenue, Detroit 48226

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

H. A. Towsley, MD, Chairman, W5610 University Hospital, Ann Arbor 48104

J. R. Heidenreich, MD, Vice Chairman, Daggett 49821

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

R. M. Stow, MD, Chairman, 2909 E. Grand River, Lansing 48912

COMMITTEE ON PUBLIC RELATIONS

B. E. Brush, MD, Chairman, 2799 W. Grand Blvd., Detroit 48202

COMMITTEE ON RESPIRATORY DISEASES

R. A. Rasmussen, MD, Chairman, 1810 Wealthy Street, SE, Grand Rapids 49501

COMMITTEE ON RURAL MEDICAL SERVICE

R. E. Rice, MD, Chairman, 420 S. Bower Street, Greenville 48838

COMMITTEES OF THE COUNCIL

Appointed by Council Chairman Ross V. Taylor, M.D.

(Following are the names of the chairmen and vice-chairmen. The full committee lists are available from MSMS.)

STANDING COMMITTEES

ADVISORY COMMITTEE TO EXECUTIVE DIRECTOR

R. V. Taylor, MD, Chairman, 756 W. Michigan, Jackson 49201

COUNTY SOCIETIES COMMITTEE

J. J. Coury, MD, Chairman, 1209 Tenth Street, Port Huron 48060

EDUCATION LIAISON COMMITTEE

Milton R. Weed, MD, Chairman, 1059 Berkshire Road, Grosse Pte. Park 48230

FINANCE COMMITTEE

R. K. Whiteley, MD, Chairman, 608 Eastland Center Professional Bldg., Detroit 48236

PUBLICATION COMMITTEE

B. L. Masters, MD, Chairman, 111 W. Dayton Street, Fremont 49412

* * *

LIAISON COMMITTEES

LIAISON WITH MICHIGAN HOSPITAL SERVICE

R. R. Cooper, MD, 1515 David Whitney Building, Detroit 48226

J. J. Lightbody, MD, 7815 E. Jefferson, Detroit 48214

R. V. Taylor, MD, 756 W. Michigan, Jackson 49201

LIAISON WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

H. C. Hansen, MD, Chairman, 417 Post Building, Battle Creek 49014

LIAISON WITH MICHIGAN WELFARE LEAGUE

B. M. Harris, MD, 27 So. Prospect, Ypsilanti 48917

B. L. Masters, MD, 111 W. Dayton Street, Fremont 49412

C. Allen Payne, MD, 1840 Wealthy Street, SE, Grand Rapids 49506

Otto K. Engelke, MD, Advisor, 313 Washtenaw County Building, Ann Arbor 48108

LIAISON WITH PODIATRY

Wm. H. Blodgett, MD, Chairman, 76 West Adams Street, Detroit 48226

LIAISON WITH RESIDENTS, INTERNS, SENIOR MEDICAL STUDENTS

N. D. Henderson, MD, Chairman, 726 Abbott Road, East Lansing 48823

LIAISON WITH STATE BAR OF MICHIGAN

O. J. Johnson, MD, Chairman, 207 N. Walnut, Bay City 48706

LIAISON WITH STATE BOARD OF REGISTRATION IN MEDICINE

O. J. Johnson, MD, Chairman, 207 N. Walnut, Bay City 48706

LIAISON WITH STATE EXECUTIVE OFFICE

K. H. Johnson, MD, Chairman, 1116 Michigan National Tower, Lansing 48933

LIAISON WITH MICHIGAN CHAPTER, HEALTH INSURANCE COUNCIL

B. E. Brush, MD, 2799 W. Grand Blvd., Detroit 48202

J. J. Coury, MD, 1209 Tenth Street, Port Huron 48060

Otto K. Engelke, MD, 313 Washtenaw County Bldg., Ann Arbor 48108

D. L. Kessler, MD, 540 Belvedere Drive, SE, Grand Rapids 49506

* * *

OTHER COMMITTEES

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE

H. A. Raskin, MD, Chairman, 18510 Meyers Road, Detroit 48235

COMMITTEE ON AWARDS

C. Allen Payne, MD, Chairman, 1840 Wealthy Street, SE, Grand Rapids 49506

COMMITTEE ON BEAUMONT MEMORIAL

B. M. Harris, MD, Chairman, 27 So. Prospect, Ypsilanti 48917

Otto O. Beck, MD, Honorary Chairman, 308 Wabeek Building, Birmingham 48011

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

R. O. Kraft, MD, Chairman, 2355 E. Stadium Blvd., Ann Arbor 48104

H. A. Towsley, MD, Vice Chairman, W5610 University Hospital, Ann Arbor 48104

A. J. Walt, MD, Vice Chairman, Detroit Receiving Hospital, Detroit 48226

COMMITTEE ON EMERGENCY AND DISASTER MEDICAL SERVICES

C. P. Anderson, MD, Chairman, 640 Temple Avenue, Detroit 48201

COMMITTEE ON EYE CARE

R. T. Blackhurst, MD, Chairman, 233 E. Larkin, Midland 48640

COMMITTEE ON HOSPITAL RELATIONS

A. C. Stander, MD, Chairman, 1411 Court Street, Saginaw 48602

COMMITTEE ON INTERNATIONAL HEALTH

H. A. Branch, MD, Chairman, 817 Mott Foundation Bldg., Flint 48502

COMMITTEE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS

G. A. O'Connor, MD, Chairman, University of Michigan Medical Center, Ann Arbor 48104

COMMITEE ON MEDICINE AND RELIGION

W. G. Fox, MD, Chairman, 715 N. University, Ann Arbor 48104

COMMITTEE ON MICHIGAN MEDICAL HISTORY

J. R. G. Gosling, MD, Chairman, 315 Corrie Road, Ann Arbor 48105

COMMITTEE ON NURSING

R. L. Tupper, MD, Chairman, 86 Ottawa Drive, Pontiac 48053

COMMITTEE ON REHABILITATION

(Chairman to be appointed)

COMMITTEE ON RELATIVE VALUE STUDY

(Chairman to be appointed)

COMMITTEE TO STUDY HEALTH PROBLEMS OF THE DISADVANTAGED IN THE CITIES

F. B. Walker, MD, Chairman, 1206 Balfour Road, Grosse Pte. 48230

COMMITTEE TO MEET WITH MEDICAL SPECIALTY GROUPS

C. Allen Payne, MD, Chairman, 1840 Wealthy Street, SE, Grand Rapids 49506

COMMITTEE ON ORTHODONTICS

R. O. Dingman, MD, Chairman, 221 N. Ingalls, Ann Arbor 48104

COMMITTEE ON QUACKERY

J. N. Schaeffer, MD, Chairman, 261 Brady, Detroit 48201

Directory, Listed by Component Medical Societies

Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; "O" for Osteopathic Associate Members; all others are Active Members (Numbers in parentheses indicate County Society Code Numbers used in Alphabetical Roster.)

ALLEGAN COUNTY MEDICAL SOCIETY (10)

Brachman, A. Peter, Jr...222 Trowbridge St., Allegan 49010
Brown, Lewis F. (R)...451 W. Allegan St., Otsego 49078
Chase, Walter E........137½ N. Main St., Plainwell 49080
Clark, James I....................Box B, Fennville 49408
Everett, D. W.......Plainwell Sanitarium, Plainwell 49080
Goddard, G. B..............218 E. Orleans, Otsego 49078
Goude, Albert G. (A)
Hays, James D...........................Douglas 49406
Johnson, Elwin B...........412 Water St., Allegan 49010
Johnson, Harrison H. (L)...............Wayland 49348
Keeler, Van O. ....304 Dix St., Otsego 49078
Mahan, James E.......402 Trowbridge St., Allegan 49010
Medill, Wilbur C. (R)...139 N. Main St., Plainwell 49080
Miller, Kenneth C.....................Saugatuck 49453
Plogenhoef, Richard...........304 Dix St., Otsego 49078
Pone, Janis..............................Martin 49070
Ramseyer, Gladwin E......125 E. Bridge, Plainwell 49080
Schneiter, Harry E.........425 Cutler St., Allegan 49010
Schock, William H........315 Maple St., Saugatuck 49453
Southern, Edward.......................Allegan 49010
Topp, E. Robert..........500 Allegan St., Plainwell 49080
Topp, Elwin W...........353 Naomi St., Plainwell 49080
Van Der Kolk, Bert....................Hopkins 49328
Vandervoord, Gerald....312 E. Plum St., Wayland 49348
Vaughan, Willard R. (L)..............Plainwell 49080
Wiseman, Bertha A...............Box 177, Allegan 49010

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

Aliferis, Peter........Alpena General Hosp., Alpena 49707
Arscott, Edward F...................Rogers City 49779
Brown, Donald C......312 E. Chisholm St., Alpena 49707
Bunting, John W..........110 N. 1st Ave., Alpena 49707
Burkholder, H. J. (L)..122 N. Second Ave., Alpena 49707
Cohn, Stuart L.......1253 W. Washington, Alpena 49707
Constantine, Aeneas..................Harrisville 48740
Cook, Thomas J.......312 E. Chisholm St., Alpena 49707
Finch, Donald E.......................Onaway 49765
Foley, Richard.....................Rogers City 49779
Fox, William L.......601 W. Chisholm St., Alpena 49707
Grause, Thomas J.....312 E. Chisholm St., Alpena 49707
Greenwood, James........115 N. First St., Alpena 49707
Guner, Ali.......Alpena General Hospital, Alpena 49707
Hier, Edward A.......125 N. Second Ave., Alpena 49707
Jackson, Wm. F...............RFD 1, Huron Shore Dr., Rogers City 49779
Kutsche, W. F...............208 Lake St., Oscoda 48753
Leopard, J. M............312 E. Chisholm, Alpena 49707
Nesbitt, Wm. E...........123 N. 2nd Ave., Alpena 49707
Newman, Roy E.....Alpena General Hosp., Alpena 49707
O'Dell, F. C., Jr.......110 W. Chisholm St., Alpena 49707
Parmenter, Elbert S. (L)..316 W. Third, Dixon, Ill. 61021
Ramsey, J. A.............312 E. Chisholm, Alpena 49707
Ries, Robt. C.....573 N. Bradley Hwy., Rogers City 49779
Riker, John L.........601 N. Second Ave., Alpena 49707
Spens, James E........123 N. Second Ave., Alpena 49707
Stibitz, Henry B.......1065 US 23 North, Alpena 49707
Stump, G. D...............113 State Ave., Alpena 49707
Wagoner, Darwin E............5007 N. Cedar Lake Rd., Oscoda 48753
Watkins, T. M.........312 E. Chisholm St., Alpena 49707
Wienczewski, T. W.......919 N. 2nd Ave., Alpena 49707
Wilson, Chas. S. (L).......730 State Ave., Alpena 49707

BARRY COUNTY MEDICAL SOCIETY (18)

Blair, Larry..............110 W. Center, Hastings 49058
Brown, Jack A..............535 Francis, Hastings 49058
Castleman, Douglas H....146 E. State St., Hastings 49058
Finnie, Gordon M.......Pennock Hospital, Hastings 49058
Finnie, Raymond G. (A)..535 E. Francis, Hastings 49058
Gwinn, Alexander B. (L)........1016 San Lucia Dr. SE, Grand Rapids 49506
Heaslip, Jos. D. (R)..............13800 83rd Place N., Largo, Florida 33540
Hoffs, Marinus A.......911 Fourth St., Lake Odessa 48849
Huebner, R. J.............110 W. Center, Hastings 49058
Lofdahl, Stewart (R) R. 1, Box 172, St. Charles, Ill. 60174
Logan, Wesley G........City Bank Bldg., Hastings 49058
Lundeen, John G.....................P.O. Box 2213 B, Port Au Prince, Haiti B.W.I.
Morrill, Charles E......110 W. Center St., Hastings 49058
Myers, Thos. W.........307 N. Main St., Nashville 49073
Noah, Melvin L......................Middleville 49333
Phelps, Everett L. (A)..535 E. Francis St., Hastings 49058
Pryor, Robt. B...........400 W. State St., Hastings 49058
Spindler, James R......110 W. Center St., Hastings 49058
Tromp, Jack L..............R. D. 3, Lake Odessa 48849

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A.........1420 Center Ave., Bay City 48706
Alcorn, Marshall W.....1420 Center Ave., Bay City 48706
Alis, Asim K.........1803 Borton Ave., Essexville 48732
Allen, Arthur D. (L)....101 W. John St., Bay City 48706
Antle, Robert C.........101 W. John St., Bay City 48706
Asbury, Richard B.........2110 16th St., Bay City 48706
Asline, John N........207 N. Walnut St., Bay City 48706
Austin, Justus J. (R).................Tawas City 48763
Bickham, Richard E......101 W. John St., Bay City 48706
Bowman, David A..............1815 Wm. H. Taft Rd., Cincinnati, Ohio 45206
Bozdech, Jiri Josef.......900 N. Jackson, Bay City 48706
Brenner, Frederick......1805 Sixth Street, Bay City 48706
Brinkman, Harvey H...116 W. State St., East Tawas 48730
Brown, Geo. M. (L)...207 N. Walnut St., Bay City 48706
Buechle, George T...............175 E. Pinconning Dr., Pinconning 48650
Cajigas, Tomas R....1908 Columbus Ave., Bay City 48706
Campbell, Donald A.........700 Borton, Essexville 48732
Campbell, John S...2107 Sixteenth Street, Bay City 48706
Chapin, Fredk. J......State Hospital, Traverse City 49684
Cook, Hugh K...........101 W. John St., Bay City 48706
Cook, Raymond R.......1115 Fifth Street, Bay City 48706
Cooper, James C...........410 Hart St., Essexville 48732
Cosens, Stanley A........101 W. John St., Bay City 48706
Crissey, Robt. R.........101 W. John St., Bay City 48706
Criswell, Robt. H. (L)........3419 Portage Blvd., #43, Fort Wayne, Ind. 46804
Csonka, Nicholas....1308 Columbus Ave., Bay City 48706
Dardas, Michael J......1413 Center Ave., Bay City 48706
Davis, James H..........1308 Columbus, Bay City 48706
Dolbee, Malcolm K.............Box 518, Standish 48658
Ferguson, Robert........101 W. John St., Bay City 48706
Fischer, Hans.........................Standish 48658
Follis, Wm. M.............101 W. John, Bay City 48706
Gamble, Wm. G., Jr. (L)..2010 5th Ave., Bay City 48706
Gehman, J. R..........................Standish 48658
Geneczko, John T....1308 Columbus Ave., Bay City 48706
Grigg, John W.........2110 Sixteenth St., Bay City 48706
Gueramy, Mono........1411 Center Ave., Bay City 48706
Hafford, Robert C........101 W. John St., Bay City 48706
Hagelshaw, Gayland L....101 W. John St., Bay City 48706
Heuser, Harold H...916 Washington Ave., Bay City 48706
Horowitz, Saml. F......1415 Center Ave., Bay City 48706
Howland, Walter L......2110 E. 16th St., Bay City 48706
Jacques, J. E.........................Tawas City 48763
Jaffe, Martin D..........2110 16th Street, Bay City 48706
Jens, Otto F. (L)....................Essexville 48732
Johnson, Orlen J. (L)..207 N. Walnut St., Bay City 48706
Jones, M. Culver........900 N. Jackson, Bay City 48706
Jones, Tyre K., III (M).............102 N.W. 33rd St., Mineral Wells, Texas 76067
Kelly, Larry Stanley..................Tawas City 48763
Kessler, Mana (L)......311 Center Ave., Bay City 48706
Kessler-Frux, Sabina (L).311 Center Ave., Bay City 48706
Knobloch, Howard T.....1102 Columbus, Bay City 48706
Kovacsi, Laszlo..........820 N. Johnson, Bay City 48706
Kulinski, Eugene J.........2110 16th St., Bay City 48706
Lambert, Leslie A. (R)..........R 1, East Tawas 48730
Langin, John L.............100 15th St., Bay City 48706
Loan, G. B........Essexville Mdcl. Bldg., Essexville 48732
Loree, Joseph..........1407 Center Ave., Bay City 48706
MacRae, Leonard D.....813 Sherman St., Bay City 48706
Mayne, John C..........101 W. John St., Bay City 48706
McGee, Harry B...........101 W. John, Bay City 48706
McGee, Peter L...........2110 16th St., Bay City 48706
McSherry, Leo B., Jr..1308 Columbus Ave., Bay City 48706
Medvezky, Michael J. (R)........1106 S. Madison Ave., Bay City 48706
Miller, Edwin C.........101 W. John St., Bay City 48706
Moeller, Arlyn.........700 Borton Ave., Essexville 48732
Moore, Allen B.........700 Borton Ave., Essexville 48732
Moore, Neal R............2138 Fifth St., Bay City 48706
Mosier, Dwight J.........101 W. John St., Bay City 48706
Parks, Floyd R., Jr.......101 W. John St., Bay City 48706
Payea, Norman P.....217 Newman St., East Tawas 48730
Pearson, Stanley M.......101 W. John St., Bay City 48706
Pederson, B. L........East Medical Bldg., Bay City 48706
Pelczar, Walter E........2786 Oak Place, Bay City 48706
Prophater, Robt. C....202 Boehringer Ct., Bay City 48706
Reidinger, Alan A. (M)..4307 Elmwood, Royal Oak 48073
Rodda, E. H............101 W. John St., Bay City 48706
Rowe, Paul W...........Mercy Hospital, Bay City 48706
Salman, Feyyaz.......1221 Orchard Rd., Essevxille 48732
Schmelzer, Wm. J.............602 Mercer St., P.O. 746, Pinconning 48650
Shafer, Harold C........101 W. John St., Bay City 48706
Shields, Hubert L.......101 W. John St., Bay City 48706
Standiford, David.........2110 16th St., Bay City 48706
Stroia, Livius N.........101 W. John St., Bay City 48706
Sutton, R. L., Jr......116 W. State St., East Tawas 48730
Taheri, Zia E........1411 Center Avenue, Bay City 48706
Tarter, Clyde S. (R)...........Star Route, Alpena 49707
Tompkins, Dana A...................Pinconning 48650
Treadway, Gaylord.......900 N. Jackson, Bay City 48706
Vail, Harry F.......564 W. Hampton Rd., Essexville 48732
Vanasupa, P............101 W. John St., Bay City 48706
Way, John H. (M)..............Med. Center, Okinawa, APO San Francisco, California 96331
Wilson, Thos. G. (R)..R. 2, Box 112H, Tawas City 48763
Woodburne, Harris L....1420 Center St., Bay City 48706
Wright, Thomas B.......101 W. John St., Bay City 48706
Ziliak, Alois L. Jr...3347 Highland Woods, Bay City 48706

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R.......2817 S. State St., St. Joseph 49085
Atkinson, Robert L...2821 S. State Street, St. Joseph 49085
Bailey, John H...2150 Samuel Ave., Benton Harbor 49022
Beal, Gerald N...Sheperd Benning Bldg., St. Joseph 49085
Benner, Wm. H..960 Agard St. Lab., Benton Harbor 49022
Bhisitkul, Iam P.............1 South 5th St., Niles 49120
Bieri, Dixon L....645 Riverview Dr., Benton Harbor 49022
Bliesmer, August F.....505 Pleasant St., St. Joseph 49085
Bock, William C.....505 Pleasant Street, St. Joseph 49085
Brink, John W...........807 Myrtle St., St. Joseph 49085
Bronfenbrenner, Jack...............687 E. Empire Ave., Benton Harbor 49022
Bruni, John R..............1 South Fifth St., Niles 49120
Bunker, Frank H...858 Pipestone St., Benton Harbor 49022
Cadieux, Hale W. 645 Riverview Dr., Benton Harbor 49022
Camp, Donald C.........8 N. St. Joseph Ave., Niles 49120
Carter, John H.................687 E. Empire Avenue, Benton Harbor 49022
Cawthorne, Harold J. (R)...R. 4, Box 201, Coloma 49038
Chickering, Wm. A.....2016 Lakeview, St. Joseph 49085
Cilella, S. G.............Pawating Hospital, Niles 49120
Colligan, Joseph (A) University Hospital, Ann Arbor 48104
Conway, Jos..............358 N. Main, Watervliet 49098
Conybeare, Robt. C...756 Pipestone, Benton Harbor 49022
Cooke, Weldon..................Berrien General Hosp., Berrien Center 49102
Cooper, Wm. L.............Rt. 4, Box 78, Coloma 49038
Crowell, Richard C...................645 Riverview Dr., Benton Harbor 49022
Dailey, Walter S..............122 Grant St., Niles 49120
Dalgleish, Archie J.....460 N. Main St., Watervliet 49098
Doolittle, John E.....9 S. St. Joseph Avenue, Niles 49120
Eidson, Hazel D. (L).............Berrien Springs 49103
Elghammer, Richard M...............1850 Colfax Ave., Benton Harbor 49022
Emery, Clayton S. (L)..1329 Lake Blvd., St. Joseph 49085
Emery, Wm. K.........1020 Niles Ave., St. Joseph 49085
Faber, Michael....756 Pipestone St., Benton Harbor 49022
Fattic, Grover R., Jr.....61 N. St. Joseph Ave., Niles 49120
Feeley, Marshall J......2516 Niles Ave., St. Joseph 49085
Friedman, Morris E.................115 N. Barton St., New Buffalo 49117
Galles, James O........429 Paw Paw Ave., Coloma 49038
Gillette, Clarence (L).....RFD 4, M-60 W, Niles 49120
Gould, Samuel H...1850 Colfax Ave., Benton Harbor 49022
Grayson, Chas. J..........4 Maple St., Three Oaks 49128

Green, Barbara G...2600 Morton Street, St. Joseph 49085
Green, Robt. L......2600 Morton Street, St. Joseph 49085
Grundset, Harold M....61 N. St. Joseph Ave., Niles 49120
Guaty, Nestor C...858 Pipestone St., Benton Harbor 49022
Gustin, Ralph D.....P.O. Box 159, Berrien Springs 49103
Haight, Arthur S. 645 Riverview Dr., Benton Harbor 49022
Hassan, D. Kent........802 E. Front St., Buchanan 49107
Haupt, Edward C...687 E. Empire, Benton Harbor 49022
Hayes, Thos. P. (A)............Univ. of Pa. Grad Hosp., 19th and Lombard, Philadelphia, Pa. 19146
Henderson, Fred C.............703 E. Main, Niles 49120
Hershey, Noel J...............P.O. Box 222, Niles 49120
Hills, David W...........2821 State St., St. Joseph 49085
Howard, Frank W....756 Pipestone, Benton Harbor 49022
Hudnutt, Dean..........807 Myrtle St., St. Joseph 49085
Huff, Harold D...............126 Main St., Niles 49120
Irgens, Edwin R. 11 Peoples St. Bk. Bldg., St. Joseph 49085
Johnston, Wm. H........715 Market St., St. Joseph 49085
Kelsall, Harvey I........1600 Niles Ave., St. Joseph 49085
Kennedy, F. Alan 315 Fidelity Bldg., Benton Harbor 49022
Kilic, Orhan.............8 N. St. Joseph St., Niles 49120
King, Frank A., Jr....858 Pipestone, Benton Harbor 49022
Klos, Henry J........2700 Highland Ct., St. Joseph 49085
Koh, Nan Kyung.............Berrien Co. Health Dept., St. Joseph 49085
Landgraf, Robt. L.............P.O. Box 222, Niles 49120
Lanting, Helen E. P.....2002 State St., St. Joseph 49085
Learned, David W..................645 Riverview Dr., Benton Harbor 49022
Lee, Hai Soon........711 Beechwood Drive, Niles 49120
Leva, John B......1122 Salem Ave., Benton Harbor 49022
Lindenfeld, Fredk. H....8 N. St. Joseph Ave., Niles 49120
Lininger, Richard E...2712 Highland Ct., St. Joseph 49085
Linn, Frank................2522 Niles, St. Joseph 49085
Maddock, Gene E...........Mercy Hosp. X-Ray Dept., Benton Harbor 49022
Manning, John T.....2817 So. State St., St. Joseph 49085
McDonald, James L.....2516 Niles Ave., St. Joseph 49085
McLelland, J. T..............Mercy Hosp. X-ray Dept., Benton Harbor 49022
Mesirow, Stanley M................687 E. Empire Ave., Benton Harbor 49022
Moore, T. Scott..............P.O. Box 416, Niles 49120
Namtze, Chan...............302 Broadway, Niles 49120
O'Toole, John.......133 E. Napier, Benton Harbor 49022
Ozeran, Chas. J......127 E. Napier, Benton Harbor 49022
Padelford, Wm. J...206 Whipple Blvd., South Lyon 48178
Payne, Charles E...925 Pipestone St., Benton Harbor 49022
Peshka, David K.......61 N. St. Joseph Ave., Niles 49120
Polansky, Sanford...84 W. Main St., Benton Harbor 49022
Porter, Chas. B...1589 Colfax Ave., Benton Harbor 49022
Quadir, Michael Syed......P.O. Box 326, Fennville 49408
Rambo, Joseph J..........555 Lake St., Bridgman 49106
Ray, Dean K...............2522 Niles, St. Joseph 49085
Reagan, Robt. E.......232 Windsor, Benton Harbor 49022
Rizzo, Albert..........2912 S. State St., St. Joseph 49085
Rooks, J. F. Girard...2002 S. State St., St. Joseph 49085
Ruth, J. Griswold..1304 Seneca Rd., Benton Harbor 49022
Skinner, James W.....460 Ridgeway St., St. Joseph 49085
Smith, W. B.........133 E. Napier, Benton Harbor 49022
Sori, Manuel R....858 Pipestone St., Benton Harbor 49022
Sowers, Bouton F..236 Higman Park, Benton Harbor 49022
Strayer, John W..............P.O. Box 222, Niles 49120
Sutherland, Burton M...............Berrien Gen. Hosp., Berrien Center 49102
Turner, John J.........2817 S. State St., St. Joseph 49085
Urist, Maurice D...454 Pipestone St., Benton Harbor 49022
Valantiejus, John A.............R.R. 2, Cedar Lane Farm, New Buffalo 49117
Vasquez, Andres H....11 E. Merchant, New Buffalo 49117
Vastine, Russell J., Jr....430 W. Chicago, Buchanan 49107
Westervelt, H. O. (L)..539 Pearl St., Benton Harbor 49022
Willson, Dean........756 Pipestone, Benton Harbor 49022
Wilson, Clinton W. 925 Pipestone St., Benton Harbor 49022
Wise, Warren A........505 Pleasant St., St. Joseph 49085
Woodford, Hackley E...599 E. Main, Benton Harbor 49022
Zick, Luther H.........2522 Niles Ave., St. Joseph 49085

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S.......162 Marshall St., Coldwater 49036
Bacon, Charles R.....300 E. Chicago St., Coldwater 49036
Bailey, James E., Jr...300 E. Chicago St., Coldwater 49036
Beatty, James B.....206 Coffee St., Russellville, Ala. 35653
Burke, James M..................R. 4, Coldwater 49036
Coates, Carl A....135 Stringtown, R.F.D. 1, Quincy 49082
Culver, Dean T......173 E. Chicago St., Coldwater 49036
Fraser, Robt. J.........52 Fairfield Dr., Coldwater 49036
Geib, Ormond D......133 Walnut Blvd., Rochester 48063
Gift, Jack...........274 E. Chicago St., Coldwater 49036
Gomley, Henry C......108 E. Chicago St., Bronson 49028
Heffelfinger, John C................292 E. Chicago Ave., Coldwater 49036
Hoeksema, Ronald H. 292 E. Chicago St., Coldwater 49036
Leitch, Robt. M..........401 Ann St., Union City 49094
Meier, Harold J. (L)....87 W. Pearl St., Coldwater 49036
Mooi, Henry R.......292 E. Chicago St., Coldwater 49036
Moss, Harvey L.............47 Carlyle, Coldwater 49036
Nettleman, Wm. E......87 W. Pearl St., Coldwater 49036
Olmsted, Kenneth L.......675 Monroe, Coldwater 49036
Rennell, Edwin J. Coldwater State Home, Coldwater 49036
Rick, John J...........61 E. Chicago St., Coldwater 49036
Schillinger, H. K...............Box 148, Coldwater 49036
Stewart, William K........403 Ann St., Union City 49094
Thomas, James A.....390 E. Chicago St., Coldwater 49036
Valderrama, F. P.......235 E. Chicago, Coldwater 49036
Walton, Nathaniel J...........Box 148, Coldwater 49036
Weidner, Harold R......50 Division St., Coldwater 49036
Wise, Robert..State Hm. & Trng. School, Coldwater 49036

CALHOUN COUNTY MEDICAL SOCIETY (34)

Albright, Arnold A......R. 1, Box 300, Battle Creek 49014
Allen, R. H............191 College, Battle Creek 49017
Amlicke, James....191 College Street, Battle Creek 49017
Amos, Norman H. (R).............710 North Avenue, Battle Creek 49017
Amos, Norman O...710 North Avenue, Battle Creek 49017
Anderson, Harold E.................501 Post Building, Battle Creek 49017
Azuela, Victor....124 Lakeview Ave., Battle Creek 49015
Baker, James E. (A)...VA Hospital, Battle Creek 49016
Bakken, Richard L....200 College St., Battle Creek 49017
Barden, Stuart P.........Leila Hosp., Battle Creek 49014
Baribeau, Roy H. (L)..531 Post Bldg., Battle Creek 49017
Bartels, George H...710 North Avenue, Battle Creek 49017
Becker, Harry F. (L)........Box 547, Battle Creek
Berghorst, John (A)...............89 S. Lavista Blvd., Battle Creek 49015
Bonifer, Philip P......231 North Ave., Battle Creek 49017
Bonifer, Philip P., Jr.............401 Security Bk. Bldg., Battle Creek 49014
Boswell, David E....105 N. Jefferson Ave., Marshall 49068
Brown, Robt. W....231 North Avenue, Battle Creek 49017
Buell, Martin F. (A)....V. A. Hospital, Ft. Custer 49016
Byrnes, Allen W...76 W. Minges Rd., Battle Creek 49015
Campbell, Alice F.......103 E. Mulberry St., Albion 49224
Campbell, Richard J. (R) 154 West St., Battle Creek 49017
Canlas, Marcelo............Leila Hosp., 9 Emmett Street, Battle Creek 49016
Capron, M. J., Jr.................806 Security Bk. Bldg., Battle Creek 49014
Caviness, L. Harold.................185 N. Washington, Battle Creek 49017

Chandler, Edward M..........411 Mich. Nat. Bk. Bldg., Battle Creek 49014
Chynoweth, Wm. R. (L)...............207 Post Bldg., Battle Creek 49017
Coakes, Jack E. (A)......716 Gorham St., Marshall 49068
Colquhoun, Graham F. 188 College St., Battle Creek 49017
Comai, William B.................110 Shadywood Lane, Battle Creek 49015
Cram, Ralph A............500 S. Ionia St., Albion 49224
Curry, Robt. K...........................Homer 49245
Daly, Harold L., Jr.........500 S. Ionia St., Albion 49224
Daly, Mary........................Box 7, Albion 49224
Daly, Miriam S............500 S. Ionia St., Albion 49224
Diamante, Paul J...710 North Avenue, Battle Creek 49017
Dickson, Albert R. (L)..............250 Champion St., Battle Creek 49017
Dodge, Warren M., Jr. (R)..............75 Laurel Dr., Battle Creek 49017
Fairbanks, Stephen (R).................Wellston 49689
Ferazzi, Patrick S....1018 North Ave., Battle Creek 49017
Finch, Duward L.................719 Capital Ave. SW., Battle Creek 49015
Fisher, Robt. E.................1501 W. Michigan Ave., Battle Creek 49017
Fraser, Robt. H. (L)...........1112 Security Bk. Bldg., Battle Creek 49014
Funk, L. D..............133 W. Burr Oak, Athens 49011
Giddings, A. M. (L) Battle Creek San., Battle Creek 49017
Gieser, E. Paul, Jr.........188 College, Battle Creek 49017
Gilfillan, Margery J. (L)..............125 56th Ave S., St. Petersburg, Fl. 33708
Girardot, John G.....25 W. Michigan, Battle Creek 49014
Glotfelty, Philip R.....219 N. Madison St., Marshall 49068
Gough, Joseph G...............American Legion Hosp., Battle Creek 49014
Graubner, Franklin L. Bogar Theater Bldg., Marshall 49068
Gray, J. Alan................309 Mich. Natl. Bk. Bldg., Battle Creek 49014
Green, Harold E......175 College St., Battle Creek 49017
Griffith, Jack C..............616 Mich. Nat. Bnk. Bldg., Battle Creek 49014
Halac, Mehmet E.....163 North Ave., Battle Creek 49017
Hamady, Alfred.....1018 North Ave., Battle Creek 49017
Hansen, Harvey C................65 W. Michigan Ave., Battle Creek 49014
Henderson, Philip M..........109 W. Erie, Albion 49224
Henriksen, J. D..........4 Hiawatha, Battle Creek 49015
Hibbs, Donald K....................777 S.E. Second, Deerfield Beach, Fla. 33441
Hickman, Marjorie J. (A).............1018 North Ave., Battle Creek 49017
Higgins, C. C.......710 North Ave., Battle Creek 49017
Hollis, Gabriel D. 124 Lakeview Ave., Battle Creek 49015
Holtom, Benj. G...815 Security Tower, Battle Creek 49014
Hooker, Lyle T. (A)....V.A. Hospital, Battle Creek 49016
Hubly, James W..................777 SE Second Ave., Deerfield Beach, Fl. 33441
Humphrey, Archie E...122 N. Madison St., Marshall 49068
Humphrey, Arthur A...175 College St., Battle Creek 49017
Humphrey, Herbert E. 122 N. Madison St., Marshall 49068
Huntington, John.....710 North Ave., Battle Creek 49017
Jacobson, Dwight................411 Mich. Natl. Bank, Battle Creek 49014
Jeffrey, James R. (L)..........197 N. Washington Ave., Battle Creek 49017
Johnson, Melvin, Jr.....Leila Hospital, Battle Creek 49014
Jones, Aubrey H. (A)............513 W. Michigan Ave., Marshall 49068
Jones, Ernest F. (A)..175 Island Ave., Battle Creek 49017
Jones, Tyre K............118 W. Green, Marshall 49068
Kelleher, George T....235 North Ave., Battle Creek 49017
Kinde, Matthew R. (A).250 Champion, Battle Creek 49017
Kingsley, Paul C.........191 College, Battle Creek 49017
Klopp, Edward J.......173 College St., Battle Creek 49017
Lakke, Gordon W...710 North Avenue, Battle Creek 49017
Lam, Francis L...408 Capital Ave. SW, Battle Creek 49015
Lancaster, Vance B....710 North Ave., Battle Creek 49017
Lanuti, Frank.......1018 North Ave., Battle Creek 49017
Levy, Jos., Jr........231 North Ave., Battle Creek 49017
Lewis, Welcome B. (L)..........196 Irving Park Drive., Battle Creek 49017
Long, Walter B.........................Homer 49245
Lowe, Kenneth H.....231 North Ave., Battle Creek 49017
Lowe, Stanley T. (R)................12 Hiawatha Dr., Battle Creek 49015
Lund, C. A. E.....135 Hamblin Ave., Battle Creek 49014
Maurer, James J...............616 Mich. Natl. Bk. Bldg., Battle Creek 49014
McCuaig, Alfred G................719 Capital St. SW, Battle Creek 49015
McGee, John W............105 Irwin Ave., Albion 49224
Melges, Fredk. J.................25 W. Michigan Ave., Battle Creek 49014
Moir, Hugh K. (A)..95 W. Spaulding, Battle Creek 49017
Morrison, Donald B...719 Capital S.W., Battle Creek 49015
Mullenmeister, H. F...275 Capital N.E., Battle Creek 49017
Murillo, Casmir....235 North Avenue, Battle Creek 49017
Netreba, Jules L........112 W. Mansion, Marshall 49068
Norgan, Anne F.................719 Capital Ave. S.W., Battle Creek 49015
Parkinson, Chas. E...1018 North Ave., Battle Creek 49015
Patrick, Gilbert T.................25 W. Michigan Ave., Battle Creek 49014
Patt, Albert J...........154 West St., Battle Creek 49017
Pearson, Donald J.....255 North Ave., Battle Creek 49017
Pier, Clarence T. (A)...80 Griffin Ct., Battle Creek 49015
Pipe, Lawrence D......Leila Hospital, Battle Creek 49014
Powell, C. E.........632 North Ave., Battle Creek 49017
Powell, Donna (A)......V. A. Hospital, Ft. Custer 49016
Power, John R..........154 West St., Battle Creek 49017
Robbert, John (L).......191 College, Battle Creek 49017
Roberge, Jerome T..............1001 Security Bk. Bldg., Battle Creek 49014
Rorich, Wilma C. W. (R) 86 Oaklawn, Battle Creek 49017
Rowan, Russell C..........500 S. Ionia St., Albion 49224
Royer, Clark W.................1331 W. Michigan Ave., Battle Creek 49017
Ryan, Chas. J............Leila Hosp., Battle Creek 49014
Seifert, Charles (M)..................6231 Peace Pipe, San Antonio, Tx. 78238
Sevidal, Pedro A., Jr.............512 Mich. Bank Bldg., Battle Creek 49014
Sharp, Ara D. (R).........502 Irwin Ave., Albion 49224
Shellenberger, H. M. (R).131 W. Hanover, Marshall 49068
Shipp, Leland P. 25 W. Michigan Ave., Battle Creek 49014
Sibilsky, A. Clark (A)................281 Honey Lane, Battle Creek 49015
Simpson, Robt. S................700 Capital Ave. S.W., Battle Creek 49015
Slagle, Geo. W. (L).............203 Capital Ave. N.E., Battle Creek 49017
Spencer, Collis M......308½ S. Superior St., Albion 49224
Stadle, Wendall H. (R)..........607 Jennings Landing, Gougac Lake, Battle Creek 49014
Stephenson, C. D.......154 West St., Battle Creek 49017
Stiefel, Richard A.................25 W. Michigan Ave., Battle Creek 49014
Strohmenger, Frank J..........500 S. Ionia, Albion 49224
Taylor, Clifford B..........500 S. Ionia St., Albion 49224
Tazelaar, Myron A....219 N. Madison St., Marshall 49068
Thompson, Walter C. (A)........Battle Creek Hlt. Ctr., Battle Creek 49014
Vander Kamp, Harry (A) V.A. Hospital, Battle Creek 49016
Vander Voort, Wm. V. (L).........R. 4, Hastings 49058
Verity, Lloyd E. (R)..36 Parkside Dr., Battle Creek 49017
Vetne, Gunnar......725 Capital S.W., Battle Creek 49015
Walker, Chas. S..................709 W. Van Buren St., Battle Creek 49017
Walters, John F.......163 North Ave., Battle Creek 49017
Walters, Wm. D.......175 College St., Battle Creek 49017
Wemmer, Keith S..............1472 W. Michigan Ave., Battle Creek 49017
Winslow, Sherwood B. 710 North Ave., Battle Creek 49017
Worgess, Duane R................799 Capital Ave. N.E., Battle Creek 49017
Yannitelli, S. A........710 North Ave., Battle Creek 49017
Young, John R...719 Capital Ave. S.W., Battle Creek 49015
Zaplitny, R. B.......1018 North Ave., Battle Creek 49017
Zaplitny, Sophia (A) 1018 North Ave., Battle Creek 49017
Zheutlin, Bertram......50 Adams St., Battle Creek 49015
Zindler, Geo. A...............1201 Security Bnk. Bldg., Battle Creek 49014

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M.......................Marcellus 49067
Clary, Rudolph I. (R) Indian Hills R#3, Dowagiac 49047
Comstock, L. David, Jr...417 W. High St., Dowagiac 49047
Devarona, Justo......420 W. High St., Dowagiac 49047
Guzzo, Henry V....515 Main St., Suite 1, Dowagiac 49047
Hickman, John K....108 W. Division St., Dowagiac 49047
Loupee, Sherman L. (L)...108 Orchard, Dowagiac 49047
Pierce, Kenneth C......417 W. High St., Dowagiac 49047
Smith, Lowell D........109 School St., Cassopolis 49031
Warren, Aaron K........109 School St., Cassopolis 49031

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R.....816 Ashmun St., Sault Ste. Marie 49783
Blair, H. Milton.....300 Court St., Sault Ste. Marie 49783
Clausen, Claire H. (L)..............1110 Lucerne Ave., Cape Coral, Fla. 33904
Coulter, Wm. J.................Drummond Island 49726
Finlayson, Donald D..................301 E. Spruce St., Sault Ste. Marie 49783
Hagele, Marie A......126 Park Pl., Sault Ste. Marie 49783
Hamel, Herbert E.....................St. Ignace 49781
Harrington, Harvey M. (L)..................Box 319, Sault Ste. Marie 49783
Heilman, Robert D................War Memorial Hosp., Sault Ste. Marie 49783
Howe, Donnell C., Jr. 300 Court St., Sault Ste. Marie 49783
Mackie, Thos. B......300 Court St., Sault Ste Marie 49783
McBryde, Lyman M...................416 Ashmun St., Sault Ste. Marie 49783
Mertaugh, Wm. F..................104 W. Spruce St., Sault Ste. Marie 49783
Montgomery, Benj. T. (L)................P. O. Box 39, Sault Ste. Marie 49783
Reddick, C. E..............Chippewa Co. Hlth. Dept., Sault Ste. Marie 49783
Rhind, Earl S.....Sault Polyclinic, Sault Ste. Marie 49783
Scott, Dale.......816 Ashmun St., Sault Ste. Marie 49783
Solomon, Joseph A...............Mackinac Island 49757
Thompson, Chas. F. (L)........Drummond Island 49726
Trapasso, Tony J.....816 Ashmun, Sault Ste. Marie 49783
Tygart, Robert L....301 E. Spruce, Sault Ste. Marie 49783
Venier, Anton G...816 Ashmun St., Sault Ste. Marie 49783
Wedding, Erling S.....................203 Hudson Dr., Sault Ste Marie 49783

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W...........203 W. Main St., Elsie 48831
Cook, Bruno C........................Westphalia 48894
Fillinger, Wells B. (L).....................Ovid 48866
Foo, Chas. T. (L)..1716 30th St. W., Bradenton, Fl. 33505
Grost, James M............Park Avenue, St. Johns 48879
Henthorn, Arthur C. (L).......Box 216, St. Johns 48879
Russell, Sherwood R...104 N. Oakland St., St. Johns 48879
Scott, James S..........................DeWitt 48820
Sheline, Victor L...........Medical Center, Ithaca 48847
Slagh, Earl M.............................Elsie 48831
Smith, Franklin W.......205 W. State St., St. Johns 48879
Stephenson, Wesley F...510 E. Walker St., St. Johns 48879
Stoller, Paul F........................St. Johns 48879

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C......218 S. 10th St., Escanaba 49829
Bash, Theodore L....................Bark River 49807
Bernier, A. B. (R)....624 Ludington St., Escanaba 49829
Berry, Roland E.......St. Francis Hosp., Escanaba 49829
Cretens, Mary...........567 N. Ninth, Gladstone 49837
Dehlin, James R...........8 S. 11th St., Gladstone 49837
Fitch, Donald N..........Doctor's Park, Escanaba 49829
Fyvie, James H.......202 S. Cedar St., Manistique 49854
Gordon, E. James.......117 N. 22nd St., Escanaba 49829
Groos, Louis P..........1015 S. 1st Ave., Escanaba 49829
Hockstad, Raymond.......Doctor's Park, Escanaba 49829
Hult, Otto S...........1005 Delta Ave., Gladstone 49837
LaSorsa, Armand M..................Manistique 49854
Le Mire, Donald F.....1104 S. First Ave., Escanaba 49829
Le Mire, John........1104 S. First Ave., Escanaba 49829
Le Mire, William A....1106 First Ave. S., Escanaba 49829
Maniaci, Geo...........8 South 11th St., Gladstone 49837
McInerney, Thos. A...1221 Ludington St., Escanaba 49829
Olson, Carl J..............8 S. 11th St., Gladstone 49837
Ryde, Robt. E...........1221 Ludington, Escanaba 49829
Sayani, Ian..........4792 Nakoma Drive, Okemos 48864
Theisen, Nikolaus J...1400 16th Avenue S., Escanaba 49829
Waters, Duane L.......200 S. Cedar St., Manistique 49854
Wehner, Merle E.........131 River St., Manistique 49854
Whipple, Arno.........Rural Station, Moorestown 49651

DICKINSON-IRON COUNTY MEDICAL SOICETY (54)

Addison, Earl R....412 Superior Ave., Crystal Falls 49920
Alexander, Wm. H. (L)................411 East C St., Iron Mountain 49801
Anderson, Donald T...408 Hamilton Ave., Kingsford 49801
Boyce, George H. (L)...........First Natl. Bank Bldg., Iron Mountain 49801
Boyce, George H., Jr. (A)............700 Hamilton Ave., Kingsford 49801
Carlson, Ralph E................500 Stephenson Ave., Iron Mountain 49801
Cecconi, R. D.................Commercial Bank Bldg., Iron Mountain 49801
Cooper, Chas. A..............Box 542, Stambaugh 49964
Gendzwell, Joyce..805 Vulcan Street, Iron Mountain 49801
Gladstone, Wm. R., Jr.......804 Main St., Norway 49870
Hayes, Willard N.........720 N. Main St., Norway 49870
Huron, Willis H.....106 West B St., Iron Mountain 49801
Irvine, Lionel E. (L).........Box 438, Iron River 49935
Jacobs, Donald J...Professional Bldg., Iron Mountain 49801
Kofmehl, Wm. J. (L).................Stambaugh 49964
McEachran, Hugh D..............500 Stephenson Ave., Iron Mountain 49801
Newkirk, John A......Khoury Bldg., Iron Mountain 49801
Nora, James C..........15 Eighth Ave., Iron River 49935
Pieper, Ernest....1517 S. Stevenson, Iron Mountain 49801
Retallack, Russell C...326 W. Genesee St., Iron River 49935
Roberts, Warren J. (A)...........1020 Carpenter Ave., Iron Mountain 49801
Schmutzler, Walter A................373 Woodward St., Iron Mountain 49801
Schroeder, John M.....Khoury Bldg., Iron Mountain 49801
Sherk, Douglas..........412 Superior, Crystal Falls 49920
Smith, Donald R...........Box 471, Iron Mountain 49801
Steinke, Chas. G...................517 Stephenson Ave., Iron Mountain 49801
Trump, Paul L................Commercial Bank Bldg., Iron Mountain 49801
Wollum, Arnold (A)...............R. 1, Vulcan 49892

EATON COUNTY MEDICAL SOCIETY (58)

Berg, Richard H...........162 Second St., Sunfield 48890
Brown, Byron P...541 Lansing St., Apt. 2, Charlotte 48813
Butler, Vernon C. (A)
Carothers, Danl. J........125 Lansing St., Charlotte 48813
Curtis, Keith L..........202 S. Cochran, Charlotte 48813
De Land, C. Le Roy......................Olivet 49076
Engle, Paul H. (A).......................Olivet 49076
Erhard, O. Stewart......301 Rancho, Eaton Rapids 48827
Garlock, Fred C...406 E. Jefferson St., Grand Ledge 48837
Harrod, Gordon R...................Grand Ledge 48837
Joseph, Daniel D........202 S. Cochran, Charlotte 48813
Meinke, Albert H., Jr..............800 Cumberland Dr., Eaton Rapids 48827
Myers, Albert W......................Potterville 48876
Passos, Benjamin A...304 N. Cochran Ave., Charlotte 48813
Robinson, S. R.......1140 Willow St., Grand Ledge 48837
Sevener, Lester G........236 S. Main St., Charlotte 48813
Sherman, Eber B.....501 Carlisle St., Eaton Rapids 48827
Van Ark, Bert.............511 Hale, Eaton Rapids 48827
Van Ark, Herman F.....410 Blake St., Eaton Rapids 48827
Willits, Clayton O..........127 Upland, Charlotte 48813

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick....420 S. Ballenger Hwy., Flint 48504
Adams, Albert C............5210 Lapeer Rd., Flint 48503
Adams, Burnell H..........609 S. Lynch St., Flint 48503
Alexander, Leroi J.....5003 N. Saginaw St., Flint 48505
Anderson, Harley H...11820 N. Saginaw, Mt. Morris 48458
Anderson, John L.........2765 Flushing Rd., Flint 48504
Antell, Richard A........2733 Crestwood Dr., Flint 48503
Anthony, Geo. E. R..........912 Beard St., Flint 48503
Baird, W. Claire..........2765 Flushing Rd., Flint 48504
Bald, Fredk. W............410 S. Ballenger, Flint 48504
Barbour, David A............5369 Briarcrest, Flint 48504
Barbour, Fleming A........2015 Lincoln Dr., Flint 48503
Baske, Franklin W...........923 Maxine St., Flint 48503
Batdorf, Joseph T...11325 S. Saginaw, Grand Blanc 48439
Bateman, Lawrence G.........1928 Lewis St., Flint 48506
Beck, Douglass R........5445 Fernwood Dr., Flint 48504
Becker, Eugene B.........2849 Miller Road, Flint 48503
Benkert, Jack...6211 Lake Forest Dr., Grand Blanc 48439
Benson, John C.........639 Mott Fdtn. Bldg., Flint 48502
Berman, Harry............3309 Fenton Rd., Flint 48507
Berner, Gerald P..........2765 Flushing Rd., Flint 48504
Bernstein, Eli N............311 E. Court St., Flint 48503
Berry, Robert E. L.....715 Mott Fdtn. Bldg., Flint 48502
Best, J. A....................3803 Clio Rd., Flint 48504
Beyer, Geo. D.............G 3337 W. Vienna, Clio 48420
Bogart, Leon M. (L).....503 National Bldg., Flint 48502
Bolduc, Gregoire............325 E. First St., Flint 48502
Boles, Wm. P. (L)............714 Beach St., Flint 48502
Bonet, Virgilio..........2765 Flushing Rd., Flint 48504
Bosker, Donald....1818 Longway Blvd. #302, Flint 48506
Bota, Robert A..............1623 Montclair, Flint 48503
Boyer, Peter R........100 Medical Arts Bldg., Flint 48501
Bradley, Robt. M.......1112 Mott Fnd. Bldg., Flint 48502
Brady, John L.........710 Mott Fdtn. Bldg., Flint 48502
Brain, Roy G. (L)........460 S. Saginaw St., Flint 48502
Branch, Hira E.........821 Mott Fdtn. Bldg., Flint 48502
Brasie, Donald R. (R)...R. 2, Box 436, Roscommon 48653
Briggs, Guy D. (L)..........224 E. Court St., Flint 48503
Brown, Clarence A.....926 Mott Fdtn. Bldg., Flint 48502
Bryant, Donald R.......621 Mott Fdtn. Bldg., Flint 48502
Buchanan, Gerald S.......211 S. Saginaw St., Holly 48442
Buchanan, Wm. F.........238 W. Caroline, Fenton 48430
Burkett, Leslie V..........618 Dougherty Pl., Flint 48504
Canada, Donald R....1207 N. Ballenger Hwy., Flint 48504
Canas, Robert R.......406 N. Saginaw St., Durand 48429
Carter, Norman A.......739 Mott Fdtn. Bldg., Flint 48502
Chambers, Myrton S. (L)........3402 Westwood Pkwy., Flint 48503
Chardoul, Eugene N.......202 Paterson Bldg., Flint 48502
Chase, Wm. D.......1318 N. Ballenger Hwy., Flint 48504
Chogich, John C...........1245 Dupont St., Flint 48504
Clark, Robt. L............1301 Flushing Rd., Flint 48504
Cole, Gerald G.........1818 Longway Blvd., Flint 48501
Collie, Ross J...............1812 E. 2nd St., Flint 48503
Collins, James I.........G 1128 N. Dye Road, Flint 48504
Colwell, Clifford W.......328 S. Saginaw St., Flint 48502
Congdon, David E.......9190 Pine Bluff, Flushing 48433
Conover, Geo. V.....207 Genesee Bank Bldg., Flint 48502
Conover, McClellan B...625 S. Grand Traverse, Flint 48503
Cook, Frank W............410 S. Ballenger, Flint 48504
Cook, Henry (L)....208 Genesee Bank Bldg., Flint 48502
Cookingham, Cory E...208 Medical Arts Bldg., Flint 48501
Coriasso, Louis B...............9224 Happy Hollow Ct., Grand Blanc 48439
Coyne, Kenneth M...........325 E. First St., Flint 48503
Cross, Robert L.........5221 Woodhaven Dr., Flint 48504
Cutler, G. Campbell........420 S. Ballenger, Flint 48504
Damm, John R........8483 Holly Rd., Grand Blanc 48439
Davis, Robt. C..........G 3029 Flushing Rd., Flint 48504
Dawson, Ralph E.........721 W. Sixth Ave., Flint 48503
Day, John Murray..........315 E. Court St., Flint 48503
Delzingro, Nicholas (L).....328 Main St., Davison 48423
Dettman, Carlton K...12023 N. Seymour, Montrose 48457
Dickstein, Bernard........605 National Bldg., Flint 48502
Diggs, Roy D., Jr.......4250 N. Saginaw St., Flint 48505
Dismond, Samuel R......1402 S. Saginaw St., Flint 48503
Dodds, Fredk. E. (L)........1336 Lewis St., Flint 48506
Dodds, Max E........625 S. Grand Traverse, Flint 48503
Dooley, James F.........3210 S. Dort Hwy., Flint 48507
Dwyer, William F.....625 S. Grand Traverse, Flint 48503
Dykewicz, Richard A......2744 Flushing Rd., Flint 48504
Eaton, Wayne L........926 Mott Fdtn. Bldg., Flint 48502
Eichhorn, Ernest M.......2765 Flushing Rd., Flint 48504
Eickhorst, Thos. N........2765 Flushing Rd., Flint 48504
Ekinci, Mehmet 2279 Grand Blanc Rd., Grand Blanc 48439
Elliott, Hardie B..........503 S. Saginaw St., Flint 48502
Engelman, Raymond M........2744 Flushing, Flint 48504
Esfahani, Ali A.......710 Mott. Fdtn. Bldg., Flint 48502
Ettinger, Ralph D.....238 W. Caroline St., Fenton 48430
Failing, John F., Jr.........Hurley Hospital, Flint 48502
Fan, Q. C................2002 E. Court St., Flint 48503
Farah, Ben S.............2765 Flushing Rd., Flint 48504
Farhat, Maynard M.........505 W. Court St., Flint 48503
Fee, Manson G...........108 E. Kearsley St., Flint 48502
Fernandez, Jose A.........2765 Flushing Rd., Flint 48504
Ferris, James W..............1005 Leith St., Flint 48505
Finkelstein, Theo.......1415 Broadway Blvd., Flint 48506
Fitch, Robert E.................1005 Leith, Flint 48505
Forrer, Graydon R.............2279 E. Grand Blanc Rd., Grand Blanc 48439
Friedman, Leon..........2765 Flushing Rd., Flint 48504
Fuller, Harvey T. (R)................2700 N. Hayden, Scottsdale, Az. 85257
Gerras, George Z.........1909 Lynbrook Dr., Flint 48507
Gibbons, James J.....101 Medical Arts Bldg., Flint 48501
Goetz, Rudolph..........1221 Church Street, Flint 48503
Goldberg, E. Marshall.......Hurley Hospital, Flint 48502
Golden, Evelyn.............218 E. Court St., Flint 48503
Golden, H. Maxwell.........218 E. Court St., Flint 48503
Gorne, Saul S...............619 Clifford St., Flint 48503
Griffin, Ernest P., Jr........1505 Arrow Lane, Flint 48507
Grommons, Jack R.........721 W. Sixth Ave., Flint 48503
Grover, Harold F. (L)......3433 Fenton Rd., Flint 48507
Guile, Gurdon S. (A).....1621 Dupont St., Flint 48504
Gullekson, Edwin H.......2765 Flushing Rd., Flint 48504
Gumpper, C. R.....4437 Morrish Rd., Swartz Creek 48473
Gundry, Geo. L. (L)..11736 Saginaw, Grand Blanc 48439
Gutow, Isadore H.........2765 Flushing Rd., Flint 48504
Gutow, Julius J..........726 Church Street, Flint 48503
Gutow, Richard F. (A) P. O. Box 6085, Denver, Co. 80240
Gutowitz, Erwin......420 S. Ballenger Hwy., Flint 48504
Hackley, Richard D...........1818 R. T. Longway Blvd., Flint 48501
Hague, Robt. F. (L)......8231 River Rd., Flushing 48433
Hallitt, John Wm.....102 Medical Arts Bldg., Flint 48501
Harper, Robt. H............713 Thomson St., Flint 48503
Harris, Bernard J.............1750 Lynbrook, Flint 84507
Harris, Donald R..........2429 Welch Blvd., Flint 48504

Hauser, Fredk. V......1015 Mott Fdtn. Bldg., Flint 48502
Hawkins, James E..........4618 Roberts St., Flint 48501
Heinemann, Herman J.....G7316 Calkins Rd., Flint 48504
Helcher, Phyllis O.....G5303 Flushing Rd., Flushing 48433
Helferty, Robert D.....1116 Ann Arbor Street, Flint 48503
Helmer, Fredric A. (A)...............275 Kings Point, Great Neck, L.I., N.Y. 11024
Hennessy, Charles R.....517 Mott Fdtn. Bldg., Flint 48502
Hiscock, Harold H. (L)..........1315 Mott Fdtn. Bldg., Flint 48502
Hockman, Thomas A.............11125 Old Bridge Rd., Grand Blanc 48439
Hodges, Frank V...........Hurley Hospital, Flint 48502
Hollis, John W.............4300 S. Saginaw, Flint 48507
Hooper, Virgil R............4230 Trumbull, Flint 48504
House, Robert J........5481 Sugarbush Lane, Flint 48504
Hubbard, Wm. C. .....302 Paterson Building, Flint 48502
Hufton, Wilfrid L.........2765 Flushing Rd., Flint 48504
Hunt, Richard J. 6259 Lake Forest Dr., Grand Blanc 48439
Hurd, Clayton E...........205 Lincoln St., Fenton 48430
Irish, Lawrence R...........6146 Sierra Pass, Flint 48504
James, Robt. E.............1860 Hampden, Flint 48507
Janke, Walter H........603 Mott Fdtn. Bldg., Flint 48502
Johnson, A. H., Jr...........429 North St., S.W., #506, Washington, D.C. 20024
Johnson, Frank D.................12606 Via Catherine, Grand Blanc 48439
Johnson, Raymond E.................5173 W. Reid Rd., Swartz Creek 48473
Judd, Alvin E.............1620 N. Franklin, Flint 48506
Karr, Paul H...............3416 Lapeer Rd., Flint 48503
Kaufman, Lewis D.......4002 N. Saginaw St., Flint 48505
Kelly, James E............2765 Flushing Rd., Flint 48504
Kennett, Donald M.................315 Bella Vista Dr., Grand Blanc 48439
Kimbrough, C. B.........1402 S. Saginaw St., Flint 48503
Kitto, Harold J...............902 Stockdale, Flint 48504
Kline, O. F...............2765 Flushing Rd., Flint 48504
Knapp, Wm. D..........503 S. Saginaw St., Flint 48502
Knoblich, Roman R..........Hurley Hospital, Flint 48502
Koop, Chester S.....1372 N. Ballenger Hwy., Flint 48504
Kreel, Boris W.......11610 Hazel St., Grand Blanc 48439
Kretchmar, Arthur H. (L)..........481 St. Andrews Dr., Aptos, Calif. 95003
Laird, James I..........12010 Kipp Rd., Goodrich 48438
Laurel, Richard J..........1207 N. Ballenger, Flint 48504
La Vielle, Carroll J.........1135 N. Dye Rd., Flint 48504
Leach, J. Leonidas (L)..5014 N. Saginaw St., Flint 48505
Le Mieux, Leslie L........701 W. Dayton St., Flint 48504
Levine, Mark C.........G3083 Flushing Rd., Flint 48504
Lewis, Billie...........739 Mott Fdn. Bldg., Flint 48502
Lewis, Thos. E...........4071 Richfield Rd., Flint 48506
Lewis, Vivian M............1618 Kensington, Flint 48503
Lieber, Robt. W.......6144 Pebbleshire Circ., Flint 48507
Lightfoot, Arthur S..........4500 Detroit St., Flint 48505
Limbach, David R............900 Begole St., Flint 48503
Lindman, Thomas C.........2484 Nolen Dr., Flint 48504
Livesay, Jackson E. (L)...503 S. Saginaw St., Flint 48502
Lundeen, Richard M..............3393 Clio, Flint 48504
Lusk, John A........9233 W. Davison Rd., Davison 48423
Lyttle, Sydney N.....1207 N. Ballenger Hwy., Flint 48504
MacKenzie, J. W., Jr.................4437 Morrish Rd., Swartz Creek 48473
Macksood, Albert J.......3169 W. Pierson Rd., Flint 48504
Macksood, John M......3169 W. Pierson Rd., Flint 48504
Macksood, Jos. A........3169 W. Pierson Rd., Flint 48504
Macksood, William E.....3169 W. Pierson Rd., Flint 48504
MacPhail, Albert A.......3302 Hawthorne Dr., Flint 48503
Mangelsdorf, C. H..........G3393 Clio Rd., Flint 48504
Manwaring, John T.......G5432 Calkins Rd., Flint 48504
Markunas, Paul J........4002 N. Saginaw St., Flint 48505
Martin, James A........812 S. Adelaide St., Fenton 48430
Martins, Helio B. F...........714 Beach St., Flint 48502
Mathias, Berton J.........1301 Flushing Rd., Flint 48504
McAlindon, J. D...............1601 Euclid, Flint 48503
McClellan, Junius W....Buick Motor Division, Flint 48505
McGrae, John D., Jr.......2433 Welch Blvd., Flint 48504
McGregor, Allan R.....G 3337 W. Vienna Rd., Clio 48420
McLeod, Kenneth W. A....2765 Flushing Rd., Flint 48504
McMurray, Richard J......2765 Flushing Rd., Flint 48504
McNaughton, D. W...2437 Pinewood Ct., Flushing 48433
McTaggart, David.....625 S. Grand Traverse, Flint 48503
Mendrek, H. H...........2765 Flushing Rd., Flint 48504
Michael, Sidney R.........922 Welch Blvd., Flint 48504
Michels, Robt. M.........2702 Flushing Rd., Flint 48504
Michelson, Richard B...........2014 Robt. T. Longway, Flint 48503
Mikat, Kurt W..........3402 Santa Clara Ct., Flint 48504
Miller, Loren E...........2645 Corunna Rd., Flint 48503
Miltich, Anthony J.....915 S. Grand Traverse, Flint 48503
Moeller, Jan C..........3102 Westwood Pky, Flint 48503
Moore, Glenn E.............323 W. Second, Flint 48503
Morgan, Alan L.........3169 W. Pierson Rd., Flint 48504
Morin, Paul................1968 Miller Rd., Flint 48503
Morrissey, Vaughn H.......101 Stockdale St., Flint 48503
Mosier, Edward C.........1730 Overhill Dr., Flint 48503
Mueller, Willys F.......13335 Pamona Dr., Fenton 48430
Murphy, E. Grant......926 Mott Fdtn. Bldg., Flint 48502
Nassar, S. H..........8483 Holly Rd., Grand Blanc 48439
Newman, Harry S...........302 E. Court St., Flint 48503
Newton, Barnabas (A).....McLaren Hospital, Flint 48502
Nicholls, Wm. W..........806 W. Sixth Ave., Flint 48503
Nitz, Donald A.....1818 Robert T. Longway, Flint 48503
Odle, Ira D. (L)...........201 Welch Blvd., Flint 48503
Oldt, Mary Ruth...........602 S. Lynch St., Flint 48503
Orr, John W. (L).....Orrs Pt., Lk. Fenton, Fenton 48430
Osher, Seymour L.........315 E. Court St., Flint 48503
Pappalardo, Carlos................11314 Comway Rd., Ladue, Missouri 63131
Park, Joon H..........500 S. Grand Traverse, Flint 48503
Parliament, Burt A.........314 Ferndale Pl., Flint 48503
Pfeifer, Archibald C. (L).......9798 Palmetto Club Dr., Miami, Fl. 33157
Phelps, Lynn A........10122 Janaroy Ct., Goodrich 48438
Phillips, A. F......X-ray Dept., Hurley Hosp., Flint 48502
Pickering, Woodrow H...1602 Ballenger Hwy., Flint 48504
Pietruszka, B..............5210 Lapeer Rd., Flint 48503
Pike, Wallace W....7514 Miller Rd., Swartz Creek 48473
Platt, Alice Lee (A)...............5551 Territorial Rd., Grand Blanc 48439
Portney, Jack E..............725 Stevens St., Flint 48503
Pougnet, W. D............6155 Maple Ridge, Flint 48504
Pratz, Oliver C. (L)........1303 Detroit St., Flint 48503
Preston, Otto J.........300 N. Chevrolet Ave., Flint 48504
Price, Jack R..........410 S. Ballenger Hwy., Flint 48504
Prior, Richard W..........1266 S. Le Roy, Fenton 48430
Purcell, F. L................Ternstedt Plant, Flint 48509
Quin, John, Jr............2765 Flushing Rd., Flint 48504
Quinn, Jarlath.............1116 Ann Arbor, Flint 48503
Rabiah, Fouad........1139 Mott Fdn. Bldg., Flint 48502
Radcenko, Helen........302 W. Pierson Rd., Flint 48505
Radcenko, Leonid........302 W. Pierson Rd., Flint 48505
Rao, D. S...........1207 N. Ballenger Hwy., Flint 48504
Rapport, Richard L.........436 S. Saginaw, Flint 48502
Rathburn, Robert J........1501 Flushing Rd., Flint 48504
Rawling, John C........115 Med. Arts. Bldg., Flint 48504
Rawlings, J. Mott..........1601 Neome Dr., Flint 48503
Reid, John H.............1301 Flushing Rd., Flint 48504
Reye, George H...............2279 E. Grand Blanc Rd., Grand Blanc 48439
Rice, Alan K.........2008 Robt. T. Longway, Flint 48503
Rieth, Geo. F.............1406 Davison St., Flint 48506
Roberts, Floyd A. (L)..327 Sheffield, Apt. 281, Flint 48503
Robitaille, M. L...........2765 Flushing Rd., Flint 48504
Rowe, John B...............653 Saginaw St., Flint 48502
Rundles, Walter Z.....500 Grand Traverse St., Flint 48503
Sampaio, Carlos A.......8020 Davison Rd., Davison 48423
Sandberg, Russell G......5431 Fernwood Dr., Flint 48504
Sanocki, Fredk. E......915 S. Grand Traverse, Flint 48503
Scavarda, Chas. J..............1106 Maxine, Flint 48503
Schaefer, Richard K.......3248 Van Slyke Rd., Flint 48507
Schafer, Nelson S..........721 W. 6th Ave., Flint 48503
Schiff, Benton A.............323 W. 2nd St., Flint 48503
Schmidlin, Robt. W.........3710 Davison Rd., Flint 48506
Schreiber, E. Oskar......2765 Flushing Road, Flint 48504
Schroeder, Paul E.........1673 N. Chevrolet, Flint 48504
Schultz, J. Stanley........3327 Fleming Rd., Flint 48504
Schwartz, John M........1300 N. Dort Hwy., Flint 48506
Schwarz, Heinz H.................5551 Territorial Rd., Grand Blanc 48439
Seven, Phillip G...........2301 Cummings, Flint 48503
Seymour, Geo. D.....G7237 N. Saginaw, Mt. Morris 48458

Shantz, Leighton O. 1497 Country View Lane, Flint 48504
Sheehy, James P.........503 S. Saginaw St., Flint 48502
Sheeran, Danl. H.........610 S. Vernon Ave., Flint 48503
Sherwood, Frederick.......2765 Flushing Rd., Flint 48504
Shields, John L........234 W. Caroline St., Fenton 48430
Simoni, Lewis E.........3210 S. Dort Hgwy., Flint 48507
Singh, Sarjit........839 Mott Fndtn. Bldg., Flint 48502
Sirna, Anthony R....11219 Stonybrook, Grand Blanc 48439
Smalley, R. H.....4437 Morrish Rd., Swartz Creek 48473
Smith, Eugene C....................606 Stevens, Flint 48503
Smith, Harold O.............3769 Sunset Dr., Flint 48503
Smith, Maurice J........2801 N. Saginaw St., Flint 48505
Smith, Sidney E.......625 S. Grand Traverse, Flint 48503
Sniderman, Benj. F............727 Beach St., Flint 48502
Solik, A. E..................311 E. Court St., Flint 48503
Somach, Fredric M........2765 Flushing Rd., Flint 48504
Sorkin, Morris L..............718 Beach St., Flint 48502
Sorkin, Saml. S................718 Beach St., Flint 48502
Sorscher, Alan J.......420 S. Ballenger Hwy., Flint 48504
Southall, Warren E.........4250 N. Saginaw, Flint 48505
Sparks, Harvey V.........2765 Flushing Rd., Flint 48504
Steffe, Ralph S...........2765 Flushing Rd., Flint 48504
Steinman, Floyd H.......503 S. Saginaw St., Flint 48502
Stevens, Philip K......1116 Mott Fdtn. Bldg., Flint 48502
Stevenson, Wm. W. (L)....1521 Arrow Lane, Flint 48507
Streat, Rudolph W. (L).8100 Davison Rd., Davison 48423
Stroup, Clayton K.........2002 E. Court St., Flint 48503
Sullivan, M. R....5352 Peppermill Rd., Grand Blanc 48439
Sutherland, James K. (L).....402 E. 3rd St., Flint 48503
Sutton, Geo. D. (L).......303 W. Court St., Flint 48503
Tang, Gene D. (A)..Irwin Hosp., Ft. Riley, Kansas 66442
Tauscher, John W...2016 R. T. Longway Blvd., Flint 48503
Theuerle, Walter I.......3101 N. Saginaw St., Flint 48505
Thompson, Charles A......4211 Comstock St., Flint 48504
Thompson, Jack W.......2702 Flushing Rd., Flint 48504
Thoms, Peter S.......1279 W. Coldwater Rd., Flint 48505
Tofteland, Elmer H.......2765 Flushing Rd., Flint 48504
Tower, Rita B. (L)..............Elms Trailer Park, D4, 2801 S. Dort Hwy., Flint 48507
Turcke, Allen F............1245 Dupont St., Flint 48504
Turner, Merald G.........G 3169 W. Pierson, Flint 48504
Tuuri, Arthur L.........Mott Children Clinic, Flint 48502
Urich, Vernon..........3169 W. Pierson Rd., Flint 48504
VanBrocklin, J. D.........2765 Flushing Rd., Flint 48504
Van Duyne, Fredk. W.......2849 Miller Rd., Flint 48503
Van Harn, Raymond S.....1116 Ann Arbor St., Flint 48503
Varjavandi, Siavosh.....3169 W. Pierson Rd., Flint 48504
Varney, Howard L. 1818 Robt. Longway Blvd., Flint 48503
Varol, Adnan O.........432 N. Saginaw St., Flint 48502
Vaughan, Edgar J.........319 S. Bridge St., Linden 48451
Velarde, Nicholas N.......3083 Flushing Rd., Flint 48504
Villarreal, Virgilio............3917 Kellar St., Flint 48504
Wade, Franklin V...436 S. Saginaw St., #410, Flint 48502
Walcott, Carver G......201 E. Carolina St., Fenton 48430
Walker, James D.
Walter, Daniel L.........820 Davison Rd., Davison 48423
Ward, Nell M. (L).....G4152 Carnation Ct., Flint 48506
Weber, Richard E.....420 S. Ballenger Hwy., Flint 48504
Weber, Robt. M...........3710 Davison Rd., Flint 48506
Wentworth, John E..........420 S. Ballenger, Flint 48504
Werness, Inga W. (L)...220 East Fourth St., Flint 48503
West, George A.........4250 N. Saginaw St., Flint 48505
Wheeler, J. D..........926 Mott Fdtn. Bldg., Flint 48502
White, Carl H..............106 River St., Fenton 48430
White, Frank T............5210 Lapeer Rd., Flint 48503
Whites, Jack C.........7343 Flushing Rd., Flushing 48433
Willard, Robt. H..............718 Beach St., Flint 48502
Williams, Wm. S. (L) 5216 S. Genesee, Grand Blanc 48439
Willis, Robert E.........6606 N. Saginaw St., Flint 48505
Wills, Thos. N. (R)..Chicaugoan Lake, Crystal Falls 49920
Wolcott, Nan D. (R)....7506 Lapeer Rd., Davison 48423
Wolf, Melvyn D........G 3083 Flushing Rd., Flint 48503
Woodsides, K. T. (A)..6377 Flushing Rd., Flushing 48433
Wright, Geo. W., Jr. 2279 Grand Blanc, Grand Blanc 48439
Zeis, Myron G................718 Beach St., Flint 48502
Zelko, Daniel M...........4071 Richfield Rd., Flint 48506

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, Saml. G..........103 Suffolk St., Ironwood 49938
Davidson, Donald L.....200 S. Sophie St., Bessemer 49911
Franck, John R., Jr.....401 Sunday Lake, Wakefield 49968
Gallo, Bela.............Newport Clinic, Ironwood 49938
Gertz, Michael A......109 E. Aurora St., Ironwood 49938
Gorrilla, Allen C..........210 Suffolk St., Ironwood 49938
Harrington, Rex R., Jr...104 E. Ridge St., Ironwood 49938
Lieberthal, M. J. (L)..220 S. Suffolk St., Ironwood 49938
Lieberthal, Paul R. (L)........Box 632, Ironwood 49938
Medford, Lester....306 Sunday Lake St., Wakefield 49968
Santini, Florian J.......109 E. Aurora St., Ironwood 49938

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Barstow, Richard G. (A).................3630 Garfield, Traverse City 49684
Bartone, John R.....217 S. Madison, Traverse City 49684
Beall, John G......1105 E. Front St., Traverse City 49684
Berens, Burdette M.....................Kalkaska 49646
Blount, Harry M...........116 Cass, Traverse City 49684
Bolan, Ellis S. I..............Box 67, Suttons Bay 49682
Brownson, Kneale M.....116 Cass St., Traverse City 49684
Bushong, Benj. B.......116 Cass St., Traverse City 49684
Campbell, Thomas D..................1634 S. High St., Traverse City 49684
Cartwright, Wm. H. 1105 E. Front St., Traverse City 49684
Clark, Oswald V.......1030 Sixth St., Traverse City 49684
Cline, Theodore N...........999 6th, Traverse City 49684
Cline, Warren W............999 6th, Traverse City 49684
Coleman, John F......1100 Sixth St., Traverse City 49684
Dundon, Arthur F.....1100 Sixth St., Traverse City 49684
Edmonds, W. T.......Munson Hosp., Traverse City 49684
Ellis, Claude I.......................Suttons Bay 49682
Fiebing, Jack A........P.O. Box 283, Traverse City 49684
Fishbeck, Wm. A.....1209 E. 8th St., Traverse City 49684
Fulmer, Roger C...9838 Peninsula Dr., Traverse City 49684
Haberlein, Chas. R.....1100 Sixth St., Traverse City 49684
Hall, James W.........1100 Sixth St., Traverse City 49684
Hall, Thomas C.......1100 Sixth St., Traverse City 49684
Hamilton, Earl E....530 S. Union St., Traverse City 49684
Harwood, Jerold R.....1100 Sixth St., Traverse City 49684
Herkner, Mildred L. (A)........Traverse City St. Hosp., Traverse City 49684
Hubbell, Reader J. (L)...Rte 2, 323B, Suttons Bay 49682
Huene, Nevin......110 E. Front St., Traverse City 49684
Huston, R. R. (L)....................Elk Rapids 49629
Johnson, Robert C......116 Cass St., Traverse City 49684
Johnston, James D.....1100 Sixth St., Traverse City 49684
Kamp, Robt. L..........................Beulah 49617
Kaufman, James N........427½ Main St., Frankfort 49635
Kitti, Wm. W...........................Kalkaska 49646
Kolberg, James A......211 S. High St., Northport 49670
Komesu, Seiichi.............Box C, Traverse City 49684
Larson, Conrad E..............Munson Medical Center, Traverse City 49684
Lemen, Charles E.....110 S. Madison, Traverse City 49684
Lieding, Keith G...7844 Peninsula Dr., Traverse City 49684
Lossman, Robt. T..............J. Decker Munson Hosp., Traverse City 49684
McClay, Adam C.......6330 Pen Dr., Traverse City 49684
Michael, Stanley L.....335 Davis St., Traverse City 49684
Milliken, John G......224 Circle Dr., Traverse City 49684
Novack, Richard L.........408 Main St., Frankfort 49635
Pearson, Robt. E. (A).............611 Birchwood Ave., Traverse City 49684
Pelto, Maurice S....Munson Hospital, Traverse City 49684
Peterson, Wm. D....876 E. Front St., Traverse City 49684
Pike, Donald G.....1105 E. Front St., Traverse City 49684
Ponczek, E. J...Box C, State Hospital, Traverse City 49684
Power, Frank H.........116 Cass St., Traverse City 49684
Salon, Dayton D........1030 6th St., Traverse City 49684

Scheidler, Edw. P., Jr...............10610 Peninsula Dr., Traverse City 49684
Schroeder, Dwight M..................Northport 49670
Skendzel, L. P.....Munson Hospital, Traverse City 49684
Sladek, Edward F. (L)................123 E. Front St., Traverse City 49684
Sommerness, M. Duane.......Box C, Traverse City 49684
Sorum, F. T.................Box C, Traverse City 49684
Spencer, John R....1124 E. Front St., Traverse City 49684
Steffey, Jos. C.......116 Cass Street, Traverse City 49684
Stokes, G. Edward....1100 Sixth St., Traverse City 49684
Swartz, Fred G. (L)....612 Sixth St., Traverse City 49684
Sweeney, Bernard J....1100 Sixth St., Traverse City 49684
Thacker, Fredk. R.............Front St., Frankfort 49635
Thill, Leonard J.............Box C, Traverse City 49684
Thirlby, Richard L...228 S. Madison, Traverse City 49684
Toth, Joseph L.....318 Hamilton St., Traverse City 49684
Wagener, Creighton A. 1100 Sixth St., Traverse City 49684
Weih, Jack E......1105 E. Front St., Traverse City 49684
Weitz, Harry L.......Munson Hosp., Traverse City 49684
Wilcox, Paul H........333 Sixth St., Traverse City 49684
Wiley, Philip K.........116 Cass St., Traverse City 49684
Williams, Chas. R......416 Sixth St., Traverse City 49684
Willoughby, Gordon W......104 5th St., Frankfort 49635
Wonacott, Robert G.....107 Dexter St., Elk Rapids 49629
Wright, J. K., Jr....1105 E. Front St., Traverse City 49684
Wunsch, Richard E..................1122 E. Front St., Traverse City 49684
Young, John Harley..Children's Clinic, Traverse City 49684
Zielke, Irwin H......106 S. Madison, Traverse City 49684
Zimmerman, Jos. G..606 N. Elmwood, Traverse City 49684

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L........................Ithaca 48847
Bauer, A. Robert, Jr...412 E. Broadway, Mt. Pleasant 48858
Bayazit, Lutfi Y...............Mt. Pleasant State Home, Mt. Pleasant 48858
Baybura, Orhan..........503 E. Main St., Edmore 48829
Becker, Myron G.......................Edmore 48829
Bedo, Andrew V.......802 Gordon, Mount Pleasant 48858
Bergin, Jos. H..............112 E. Superior, Alma 48801
Blaisdell, Glenn D...1222 North Dr., Mt. Pleasant 48858
Brenner, E. J. (R)..........Central Mich. Comm. Hosp., Mt. Pleasant 48858
Burt, Loren G..............510 Prospect St., Alma 48801
Chamberlain, Ray W..................608 E. Chippewa, Mount Pleasant 48858
Chamichian, Souren L......Canal Rd., Mt. Pleasant 48858
Davis, Lionel L...314 S. Brown St., Mount Pleasant 48858
Dunlop, Donald........301 East Fourth St., Clare 48617
Fishbaugh, Wm. F., Jr......936 W. Center, Alma 48801
Graham, Bernard J........510 Prospect Ave., Alma 48801
Haddad, T. E.........712 Michigan Ave., St. Louis 48880
Hammerberg, Kuno...........622 McEwan, Clare 48617
Harrigan, Wm. L. (R)......90th at School Section Lk., Mecosta 49332
Hedges, Frank W.......215 W. Saginaw, St. Louis 48880
Henderson, B. G. (O)..320 W. Superior St., Alma 48801
Henderson, Wm. (O)..320 W. Superior St., Alma 48801
Hersee, Wm. E.....306 S. College, Mount Pleasant 48858
Hobbs, A. Deane (R)..Box 3233, Florence Vill., A Station, Winter Haven, Fl. 33880
Johnson, Frank D. (A) 806 E. Bellows, Mt. Pleasant 48858
Johnson, Philip R.................206 S. College Ave., Mount Pleasant 48858
Johnson, Robert B....................R. 1, Ithaca 48847
Juhnke, Le Roy W....................314 S. Brown St., Mount Pleasant 48858
Klauer, James D..Community Hospital, Mt. Pleasant 48858
Kumar, B. B.................Mt. Pleasant State Home, Mt. Pleasant 48858
Linn, Michael R.........Medical Arts Bldg., Alma 48801
Lusis, Alexsandrs (R)............St. Home & Tr. School, Mt. Pleasant 48858
McArthur, Stewart C.............Box 32, Rosebush 48878
Meyer, Edwin G..........................Alma 48801
Minster, John J......314 S. Brown St., Mt. Pleasant 48858
Nagler, Donald F............Route 3, Mt. Pleasant 48858
Nosan, Martin M................1105 Kent Dr., Rt. #3, Mt. Pleasant 48858
Philippon, Carlos A.....303 W. Superior St., Alma 48801
Ragan, Russell M...505 Hiawatha Dr., Mt. Pleasant 48858
Rank, Robert K................Central Comm. Hospital, Mt. Pleasant 48858
Remsberg, Richard J. (O)....309 State St., Alma 48801
Roth, Wm. J...............303 W. Superior, Alma 48801
Rottschaefer, John L.....3580 Northlawn Pk., Alma 48801
Rutt, Wilmer M...........310 Warwick Dr., Alma 48801
Sanders, Jack F.......Mich. Masonic Home, Alma 48801
Scott, Lincoln B., Jr.............R. 3, Mt. Pleasant 48858
Smith, Dennis V. (L)..............1435 Cambridge Rd., Ann Arbor 48104
Soriano, D. A.............Route #3, Mt. Pleasant 48858
Stack, Jack..............310 Warwick Rd., Alma 48801
Tilden, James F...Gratiot Community Hosp., Alma 48801
Veldhuis, Andrew H...801 Gordon Rd., Mt. Pleasant 48858
Waggoner, Richard L...712 Michigan Ave., St. Louis 48880
Wallman, C. Harry............901 State St., Alma 48801
Wickert, Leo R.....1001 Watson Rd., Mt. Pleasant 48858
Wilcox, Rex A.................525 State St., Alma 48801
Will, Theodore....314 S. Brown St., Mt. Pleasant 48858
Wilson, Earl C ....Harrison 48625
Wilton, Robert E. (O)..320 W. Superior St., Alma 48801
Wolfe, Kenneth P.........510 Prospect Ave., Alma 48801
Wood, Cornelius B...........Route 2, Mt. Pleasant 48858
Wood, John M......1108 Watson Rd., Mt. Pleasant 48858

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P...............Olin Hlth. Center, MSU, East Lansing 48823
Davis, William B. ....55 Barry, Hillsdale 49242
Day, Luther W. (A)................311 E. Ocean Ave., Lantana, Fl. 33460
Gates, Jon H. (M)...................67th Tuslog Det, APO 09380, N.Y.
Henelt, Edmond............32 S. Broad, Hillsdale 49242
Hodge, Chas. L........................Reading 49274
MacNeal, John A...........379 S. Broad, Hillsdale 49242
Mattson, H. Frazyer......32 S. Broad St., Hillsdale 49242
Peterson, Carl A.............59 Barry St., Hillsdale 49242
Powers, Ward O.......................Jonesville 49250
Reigle, Frederick C......................Litchfield 49252
Sawyer, Walter W.......61 N. Howell St., Hillsdale 49242
Smith, Clark B............252 S. Howell, Hillsdale 49242
Stein, Arthur J...........144 Budlong St., Hillsdale 49242
Strom, Arthur W.........32 S. Broad St., Hillsdale 49242
Tarr, John............................Camden 49232
Trapp, Donald G.........32 S. Broad St., Hillsdale 49242
Vear, Charles T.......252 S. Howell St., Hillsdale 49242
Wiggins, Ira W..........Box 5007, Cristobal, Canal Zone

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Aldrich, Addison B.......325 Harris Ave., Hancock 49930
Aldrich, Leonard C.......301 Quincy St., Hancock 49930
Barrios, Honorato.........424 Quincy St., Hancock 49930
Conner, William T.......146 Osceola St., Laurium 49913
DeCastilla, Pedro R.......424 Quincy St., Hancock 49930
Goodreau, Paul G.........301 Quincy St., Hancock 49930
Hillmer, Raymond E. (L)............Painesdale 49955
Janis, Anton J............208 Quincy St., Hancock 49930

Kolb, Fredk. E.........128 Calumet Ave., Calumet 49913
La Bine, Alfred (L)......Masonic Bldg., Houghton 49931
La Core, Ivan A...Rice Memorial Clinic, Houghton 49931
Lanczy, Tamas O...Baraga County Hospital, L'Anse 49946
Larson, Forrest W..........322 Shelden, Houghton 49931
Lepisto, Victor E.........210 Quincy St., Hancock 49930
Meier, Maurice D.........1033 Mine St., Calumet 49913
Moyer, Carl A..........................Baraga 49908
Murphy, Percy J......121 Calumet Ave., Calumet 49913
Otto, Howard........St. Joseph Hospital, Hancock 49930
Parker, Thomas M. (M)............U. S. Naval Hosp., Portsmouth, Va. 23708
Repola, Kenneth L. 400 Maynard St. 704, Ann Arbor 48108
Roche, Andrew M.............221 5th St., Calumet 49913
Rowe, Kenneth E.....107½ Calumet Ave., Calumet 49913
Rowell, Wilfred J. (R)..............Eagle Harbor 49951
Sandell, Samuel T..6 W. St. Andrews, Duluth, Minn. 55803
Sloan, Paul S.........609 Sheldon Ave., Houghton 49931
Stroube, John A............522 W. Third, L'Anse 49946
Williams, Marshall S...St. Joseph's Hospital, Hancock 49930
Winkler, Henry J................Box 461, L'Anse 49946

HURON COUNTY MEDICAL SOCIETY (86)

Brouillette, J. N...........106 Willis St., Bad Axe 48413
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Elliott, Chas. S.........................Pigeon 48755
Herrington, C. Clark..117 S. Port Crescent, Bad Axe. 48413
Herrington, K. B.......317 Port Crescent, Bad Axe 48413
Jones, David L........206 Heisterman St., Bad Axe 48413
Kube, Kenneth S......................Bad Axe 48413
Mullaney, J. M., Jr...108 S. Port Crescent, Bad Axe 48413
Oakes, Chas. W., Jr...............Harbor Beach 48441
Oakes, Robert W.................7890 Sand Beach Rd., Harbor Beach 48441
Rady, Gordon R....206 N. Heisterman St., Bad Axe 48413
Scheurer, Clare A........................Pigeon 48755
Sidagis, Joseph.........6 W. Main St., Sebewaing 48759
Sorensen, Maurice G............P. O. Box, Elkton 48731
Steinhardt, Edward E...Henry Ford Hosp., Detroit 48202
Turner, Phillip R.....230 S. First St., Harbor Beach 48441
Wible, Chas. F., Jr..................Sebewaing 48759
Willits, Robert A...........193 N. Main St., Elkton 48731

INGHAM COUNTY MEDICAL SOCIETY (90)

Adams, Charles......2909 E. Grand River, Lansing 48912
Agate, Geo. H.......Mich. Dept. of Hlth., Lansing 48906
Agustsson, Magnus H.............2025 W. Holmes Rd., Lansing 48910
Aiken, Donald J...Grandview & Grand Rv., Okemos 48864
Alexander, Reuben G.....701 N. Logan St., Lansing 48914
Allis, Harry D.......2909 E. Grand River, Lansing 48912
Altland, J. K...........Route 2, Box 178, Lansing 48917
Asselin, David C.......1322 E. Michigan, Lansing 48912
Badgley, Waldo O.....930 N. Washington, Lansing 48906
Baker, Thos. C........930 N. Washington, Lansing 48906
Bassett, Robt. C...1322 E. Michigan Ave., Lansing 48912
Bates, Richard.......2909 E. Grand River, Lansing 48912
Bauer, Theodore I (L)..........810 Mich. Nat. Tower, Lansing 48933
Behen, Wm. C. (L)..535 S. Capitol Ave., Lansing 48933
Behney, Charles A. (L)..........Box 4256 San Jose Dr., Bisbee, Az. 85603
Bellinger, Ernest G. (L)......Masonic Home, Alma 48801
Berden, Eleanor A......2630 Libbie Drive, Lansing 48917
Bergeest, Hans......1980 Tamarisk, East Lansing 48823
Bergeon, Milton C...1021 W. Dansville Rd., Mason 48854
Bethards, Rolland E.....Sparrow Hospital, Lansing 48902
Bevez, Frank L....3209 S. Cambridge Rd., Lansing 48910
Bingham, B. Wayne......1034 E. Saginaw, Lansing 48906
Black, Chas. E...........112 W. Allegan, Lansing 48933
Black, Gertrude C. K.............529 W. Grand River, Williamston 48895
Blair, Thomas C....1322 E. Michigan Ave., Lansing 48912
Bleil, Eugene E....1322 E. Michigan Ave., Lansing 48912
Bradford, Carl W.....832 Westlawn, East Lansing 48823
Briggs, James (A)..................Box 68, Holt 48842
Brown, Fredk. W., Jr...........831 N. Washington Ave., Lansing 48906
Brown, Joseph C. (A)..............Box 68, Holt 48842
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Budden, M. Arthur..2909 E. Grand River, Lansing 48912
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Cairns, Donald A............P.O. Box 110, Mason 48854
Calomeni, Anthony D...1850 W. Mt. Hope, Lansing 48910
Carlson, Ralph G.........225 S. Waverly, Lansing 48917
Carr, Earl I. (L)..1915 Moores River Dr., Lansing 48910
Caruso, Joseph A........701 N. Logan St., Lansing 48915
Casey, Byron L........202 M. A. C., East Lansing 48823
Chaskes, Marian I. G...210 E. Hillsdale St., Lansing 48933
Chemycz, Joseph R....4930 Hillcrest Ave., Okemos 48864
Cheney, Wm. D.....Sparrow Hosp. X-ray, Lansing 48902
Chi, Seong H. (A)..Ingham Medical Hosp., Lansing 48910
Cipparone, Joseph R...St. Lawrence Hosp., Lansing 48914
Clark, Gaius D...865 Pebblebrook Ln., East Lansing 48823
Clark, Wm. E...............131 E. Oak St., Mason 48854
Clinton, Geo. R.....................R. 2, Mason 48854
Clore, Forrest C. (M)
Collier, Beverly A......2210 Montego Dr., Lansing 48912
Collier, Richard L......2210 Montego Dr., Lansing 48912
Combs, Robert G...1023 E. Michigan Ave., Lansing 48912
Comstock, Howard C. 2909 E. Grand River, Lansing 48912
Conklu, Ilhan........401 W. Greenlawn, Lansing 48910
Cook, J. Maxwell.3911 W. Michigan Ave., Lansing 48917
Cope, Henry E. (R)...605 Westmoreland, Lansing 48915
Cordes, Jerome F.....2909 E. Grand River, Lansing 48912
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Davis, Don G...........701 N. Logan St., Lansing 48915
Dawe, C. D......1515 W. Mt. Hope Ave., Lansing 48910
De Vries, Corydon F. (L)............320 Townsend St., Lansing 48933
Dexter, Mary J. B. (A)......229 E. Maple, Mason 48854
Drolett, Alfred J. (L)..1018 Prudden Bldg., Lansing 48933
Drolett, Donald J...1322 E. Michigan Ave., Lansing 48912
Drolett, Lawrence A.....1036 Morris Ave., Lansing 48917
Dunkel, John F...Edw. W. Sparrow Hosp., Lansing 48902
Dunn, Forest M....1322 E. Michigan Ave., Lansing 48912
Edminster, Ralph R.........Sparrow Hosp. Path. Dept., Lansing 48902
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Ellis, C. Ward (L)..P.O. Box 2327, Hollywood, Fla. 33022
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Enelow, Allen J.....936 Southlawn, East Lansing 48823
Feeney, Kenneth J. 1908 Mich. Natl. Tower, Lansing 48933
Feurig, James S.......321 Kensington, East Lansing 48823
Flory, Clyde R., Jr......201 W. Hillsdale, Lansing 48933
Folkers, Leonard M.................234 Michigan Ave., East Lansing 48823
Forbes, John D. (M).................301 Effingham St., Portsmouth, Va. 23704
Fortino, Silvio P.....2909 E. Grand River, Lansing 48912
Fryer, Douglas H....Mich. Dept. of Hlth., Lansing 48906
Garlinghouse, A. John., Jr.........1322 E. Michigan Ave., Lansing 48912

Gellar, Abraham........108 Division, East Lansing 48823
George, Harry C.........335 Seymour St., Lansing 48933
Ghannam, Rasem.......919 Chester Road, Lansing 48912
Ginnebaugh, L. A. (E)...2114½ N. Bond, Saginaw 48602
Goldner, Roy E. (A)..........1318 S. Washington Ave., Lansing 48910
Govons, Sidney R...1322 E. Michigan Ave., Lansing 48912
Grey, Anna B. (L)....915 Cajon St., Redlands, Ca. 92373
Haddy, Theresa B..900 Audubon Rd., East Lansing 48823
Hames, R. E.......1322 E. Michigan Ave., Lansing 48912
Hanna, Roger J. (R)......329 E. South St., Mason 48854
Harrington, Louis E...3526 W. Saginaw St., Lansing 48917
Harris, Herbert W........919 Chester Rd., Lansing 48912
Harrison, Wm. H....834 W. St. Joseph St., Lansing 48915
Harrold, Jesse F............326 W. Ionia, Lansing 48933
Hatton, R. L.........4462 Greenwood St., Okemos 48864
Hay, Kent R........1322 E. Michigan Ave., Lansing 48912
Hayes, Robt. E.....1322 E. Michigan Ave., Lansing 48912
Hayford, Wm. D.....1028 E. Saginaw St., Lansing 48906
Heald, Gordon H...714 Abbott Road, East Lansing 48823
Heckert, Frank B. 1105 Bnk. of Lnsg. Bldg., Lansing 48933
Heckert, Jos. K. (L)..........1105 Bnk. of Lnsg. Bldg., Lansing 48933
Heerdt, Mark E..........810 W. Saginaw, Lansing 48915
Henderson, Norman D.................726 Abbott Rd., East Lansing 48823
Henshaw, Dan M.................119 E. Grand River, East Lansing 48823
Heustis, Albert E. 1111 Michigan Ave., East Lansing 48823
Hill, Thos. B.........554 Durand St., East Lansing 48823
Himmelberger, R. J.......3624 Colchester, Lansing 48906
Hiscoe, D. Bonta....2909 E. Grand River, Lansing 48912
Hochglaube, Jacque...........701 N. Logan, Suite 515, Lansing 48915
Hoffer, W. E. (L).....331 Shepard Street, Lansing 48912
Hogg, Raymond E....2909 E. Grand River, Lansing 48912
Holland, Chas. F.........810 W. Saginaw, Lansing 48915
Horvath, Francis..MSU Health Center, East Lansing 48823
Hoyt, John C.......................Box 66, Holt 48842
Huggett, Clare C...122 W. Gd. River Ave., Lansing 48906
Hunt, Andrew D., Jr.........Coll. of Human Med., MSU, East Lansing 48823
Hurth, M. S.............1717 Jerome St., Lansing 48912
Imeson, Elizabeth W................1809 Cahill Drive, East Lansing 48823
Isbister, J. L.....Dept. Health, DeWitt Rd., Lansing 48906
Iung, Omero S. (N).........411 Bartlett, Lansing 48915
Jacob, S. Sprigg, III....201 Ann St., East Lansing 48823
Jakubiak, Paul.......1975 Bloomfield Dr., Okemos 48864
Jarstfer, Bruce S.. (M)........USA, Tripler Gen. Hosp., Honolulu, Hawaii 96819
Jason, Hilliard..............Olin Mem. Hlth. Ctr., MSU, East Lansing 48823
Johnson, David B.....2909 E. Grand River, Lansing 48912
Johnson, Georgia A. L...2608 Darien Dr., Lansing 48912
Johnson, Kenneth H. (L)........1116 Mich. Nat. Tower, Lansing 48933
Johnson, Lanny L. 903 E. Grand River, East Lansing 48823
Johnson, Richard..2909 E. Grand River 202, Lansing 48912
Jones, Francis A., Jr. (R)...........815 Royal Palm Pl., Vero Beach, Fl. 32960
Jones, Lester C...2909 E. Grand River 203, Lansing 48912
Jones, Martin F......2909 E. Grand River, Lansing 48912
June, Robt. C............209 N. Walnut, Lansing 48933
Kahn, David........2909 E. Grand River, Lansing 48912
Kalmbach, Roland E. (L)........1322 E. Michigan Ave., Lansing 48912
Katlein, Stanley............2231 Heritage, Okemos 48864
Kellerman, Howard H............1322 E. Michigan Ave., Lansing 48912
Kelly, William....1203 W. Oakland Ave., Lansing 48915
Kent, A. Edith Hall (L)........Box 1167, Lansing 48904
Kent, Herbert K. (L).........Box 1167, Lansing 48904
Kenyon, Fanny H. (L)..624 LaSalle Blvd., Lansing 48912
Kinzel, Raymond C.......326 W. Ionia St., Lansing 48933
Klunzinger, W. R........326 W. Ionia St., Lansing 48933
Knisely, Wm. H. (A)...............731 Oakwood Drive, East Lansing 48823
Kovich, Eleanore (A)...............304 N. Shore Dr., St. Clair Shores 48080
Kozak, Jerome S........919 Chester Rd., Lansing 48912
Kraft, Lester C.............209 S. Main St., Leslie 49251
Landick, Robt. E., Jr.....810 W. Saginaw, Lansing 48915
Lange, Philip F......2025 W. Holmes Rd., Lansing 48910
Larkey, Paul E.......110 N. Rosemary St., Lansing 48917
Larson, Homer I....1322 E. Michigan Ave., Lansing 48912
Lauzun, Virginia D................1654 E. Grand River, East Lansing 48823
Le Duc, Don M....1322 E. Michigan Ave., Lansing 48912
Leshock, Jos. C.........701 N. Logan St., Lansing 48915
Levett, Harry L. 2909 E. Grand River Ave., Lansing 48912
Lewis, Alvin..358 Giltner Hall—MSU, East Lansing 48823
Lewis, Clayton, Jr....2909 E. Grand River, Lansing 48912
Linnell, Paul C.............701 N. Logan, Lansing 48915
Llinas, Jose J.......Ingham Med. Hospital, Lansing 48910
Long, Chas. O., Jr....2909 E. Grand River, Lansing 48912
Loree, Maurice C.....120 W. Hillsdale St., Lansing 48933
Loughrin, Harry J...1005 Abbott Rd., East Lansing 48823
Loughrin, T. D......1005 Abbott Rd., East Lansing 48823
Lovoll, Kaare............209 N. Walnut, Lansing 48933
Lucas, Thos. A........1515 W. Mt. Hope, Lansing 48910
Ludlum, Lewis C.....1126 W. Saginaw St., Lansing 48915
Maldonado, W. E........Sparrow Hospital, Lansing 48902
Mandelstamm, Maria B.............4583 Comanche Dr., Okemos 48864
Mannausa, L. R...701 N. Logan, Ste. 630, Lansing 48915
Martin, Wayne O........4765 Nakoma Dr., Okemos 48864
Marzolf, M. Finette (N)..........3315 Wisconsin N.W., Washington, D.C. 20016
Mavromatis, E.....1322 E. Michigan Ave., Lansing 48912
Mavromatis, F.....1322 E. Michigan Ave., Lansing 48912
May, Stephen G. 202 M. A. C. Avenue, East Lansing 48823
McCorvie, C. Ray (L)..........525 N.E. Hayworth Rd., Port Charlotte, Fl. 33950
McCorvie, Donald R.............Williamston Med. Bldg., Williamston 48895
McElmurry, Leland R...209 N. Walnut St., Lansing 48933
McFarlane, Donald R............1322 E. Michigan Ave., Lansing 48912
McGillicuddy, O. B. (L)........1816 Mich. Natl. Tower, Lansing 48933
McKenney, Marvin J.............1322 E. Michigan Ave., Lansing 48912
Meade, Wm. H.........1023 E. Michigan, Lansing 48912
Meinke, Richard K. 1322 E. Michigan Ave., Lansing 48912
Melick, Richard C...........326 W. Ionia, Lansing 48933
Mercer, Walter E. (R) 909 Glenhaven, East Lansing 48823
Messenger, A. L....1322 E. Michigan Ave., Lansing 48912
Miller, J. T., Jr., Lt. Cmdr. MC USNR (M)..4307 Robert Court, Wheaton, Md. 20906
Miller, Willard J......225 S. Waverly Rd., Lansing 48917
Mirkil, V. Jerome.....1740 Foxcroft, East Lansing 48823
Molina-Pung, Elba..............Olin Hlth. Ctr., MSU, East Lansing 48823
Monfort, Robt. N. (R)..300 Pacific Rd., Miami, Fl. 33149
Moore, Charles R...1322 E. Michigan Ave., Lansing 48912
Moore, Donald B...1322 E. Michigan Ave., Lansing 48912
Morrow, Robt. J. (R)................741 S.W. 2nd St., Boca Raton, Fl. 33432
Nakfoor, Eugene C...1320 S. Genesee Dr., Lansing 48915
Neering, James C...1322 E. Michigan Ave., Lansing 48912
Neuman, John R......225 S. Waverly Rd., Lansing 48917
Newitt, A. W. (L) 1616 W. Michigan Ave., Lansing 48915
Nicholas, Mildred V. 5596 Portage Lake Rd., Dexter 48130
Niland, Paul T.....1322 E. Michigan Ave., Lansing 48912
Ochsner, Paul J. (R)...Fisher Body Corp., Lansing 48915
Ojeda, Pedro.....701 N. Logan, Suite 212, Lansing 48915
Packer, John H......2909 E. Grand River, Lansing 48912
Paine, Wm. G........1028 E. Saginaw St., Lansing 48906
Palmer, R. E. (L).................1627 Wildwood Rd., Clearwater, Fl. 33516
Parker, Earl E.............207 E. Bellevue, Leslie 49251
Payne, Thomas C............2909 E. Grand River Ave., Lansing 48912
Peets, Ronald.....Gr. River & Grandview, Okemos 48864
Perry, Robert A............701 N. Logan, Lansing 48915
Philips, David P. (R)..1217 Loraine Ave., Lansing 48910
Plant, John F........2909 E. Grand River, Lansing 48912
Plesscher, Wm. H...1322 E. Michigan Ave., Lansing 48912
Pomeroy, Richard W.......Sparrow Hosp., Lansing 48912
Powell, Gerald D.......1850 W. Mt. Hope, Lansing 48910
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Reizen, Maurice S...119 W. Washtenaw St., Lansing 48904
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Richards, Frank D...1322 E. Michigan Ave., Lansing 48912
Richardson, M. L. (L)....410 Albert, East Lansing 48823
Ringer, Edward L.......122 W. Hillsdale, Lansing 48933
Robinson, Thomas H.........P.O. Box 204, Lansing 48901
Robson, Edmund J.....215 N. Walnut St., Lansing 48933
Rollstin, Robt. A.......1014 Townsend St., Lansing 48933
Ruhmkorff, Ralph H. (R)...........MSU Health Center, East Lansing 48823
Rutledge, Saml. H., Jr...........1322 E. Michigan Ave., Lansing 48912
Saenz, Hugo R........1515 W. Mt. Hope, Lansing 48910
Saker, James H.......201 W. Hillsdale St., Lansing 48933
Sander, John F. (L)....4780 Okemos Rd., Okemos 48864
Scallin, J. F.............810 W. Saginaw, Lansing 48915
Scharphorn, James (A)...1050 Wall St., Ann Arbor 48105
Scheidt, R. Rudolph.....201 W. Hillsdale, Lansing 48933
Schmidt, Harry J.....2909 E. Grand River, Lansing 48912
Schultz, Arthur E.........2700 Mt. Hope, Okemos 48864
Seger, Fred L. (L)...............1035 Cherry St. N.E., St. Petersburg, Fl. 33701
Shapiro, Hyman D...1327 E. Michigan Ave., Lansing 48912
Sharp, Mahlon S.....2909 E. Grand River, Lansing 48912
Shaw, Milton (L)......320 Townsend St., Lansing 48933
Sheets, Joseph L.....2909 E. Grand River, Lansing 48912
Sherman, Geo. A. (L)...504 Cowley, East Lansing 48823
Sichler, Harper G. (R)............1476 Stonegate Lane, East Lansing 48823
Siegel, David........2909 E. Grand River, Lansing 48912
Silverman, Irving E...2909 E. Grand River, Lansing 48912
Sleight, Justin L......2909 E. Grand River, Lansing 48912
Smith, Anthony V........116 W. Sycamore, Mason 48854
Smookler, Bernard H. 2909 E. Grand River, Lansing 48912
Snyder, Le Moyne (R)....P.O. Box S, Paradise, Ca. 95969
Snyder, Ruth C. E...............234 W. Michigan Ave., East Lansing 48823
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Spencer, J. Clyde........Sparrow Hospital, Lansing 48902
Spencer, Perry C.......320 Townsend St., Lansing 48933
Stanley, Arthur L......401 W. Greenlawn, Lansing 48910
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Stephan, Winton E.........432 S. Walnut, Lansing 48933
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Stimson, Paul R...119 E. Grand River, East Lansing 48823
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Sundell, Edwin C...1322 E. Michigan Ave., Lansing 48912
Swartz, Fredk. C......720 Seymour Street, Lansing 48906
Tamblyn, Fredk. W.....335 Seymour Ave., Lansing 48933
Thaden, D. W.......909 Abbott Rd., East Lansing 48823
Thimmig, Robt. F...1322 E. Michigan Ave., Lansing 48912
Tien, Hsin Chen........701 N. Logan St., Lansing 48915
Trager, Fredk. C...1322 E. Michigan Ave., Lansing 48912
Trescott, Robt. F...1322 E. Michigan Ave., Lansing 48912
Trimby, Robt. H...1322 E. Michigan Ave., Lansing 48912
Troost, Franklin L. (L)...4378 W. Delhi Rd., Holt 48842
Turner, Paul C.............2909 E. Grand River, #203, Lansing 48912
Urban, Eva...........540 Glenmoor, East Lansing 48823
Vanderzalm, T. P. (L)............1452 Cambridge Rd., Lansing 48910
Varner, Carol......Okemos Medical Bldg., Okemos 48864
Velten, Hubert P...1394 Red Leaf Ln., East Lansing 48823
Venier, Jos. H. 1628 Hitching Post Rd., East Lansing 48823
Wadley, Ralph (R)................Harbor Springs 49740
Walker, Leo W.....4225 Apple Tree Lane, Lansing 48917
Weber, William.......401 W. Greenlawn, Lansing 48910
Wellman, John M...1322 E. Michigan Ave., Lansing 48912
West, Chas. Carl.....2909 E. Grand River, Lansing 48912
Wiegenstein, John G...St. Lawrence Hosp., Lansing 48914
Wilcox, K. R., Jr....Mich. Dept. of Health, Lansing 48906
Wilensky, Thos.........701 N. Logan St., Lansing 48915
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Willson, Howard S. (L)..........704 Mich. Nat. Tower, Lansing 48933
Worthington, Ralph......810 W. Saginaw, Lansing 48915
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Ziel, Hermann A., Jr.............Mich. Dept. of Health, Lansing 48906

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

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Bird Wm. L...........917 W. Oak St., Greenville 48838
Birzgalis, Alfreds A........Ionia State Hosp., Ionia 48846
Buck, Jack H..................517 Division, Ionia 48846
Bunce, Leo W..........................Trufant 49347
Campbell, Richard E...........104 S. Kidd, Ionia 48846
Colon-Bonet, Cesar H.............Lakeview Med. Ctr., Lakeview 48850
Dunkin, Lloyd S........410 S. Clay St., Greenville 48838
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Halick, John...........200 S. Franklin, Greenville 48838
Hansen, Carl M.........................Stanton 48888
Haskell, Robt. H. (L).........Zetlands Estate T.W.R., Nevis, Leeward Isl., B.W.I.
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Kazmers, Nikolas.....................Lakeview 48850
Kopchick, Jos...........................Muir, 48860
Kozachik, Martin J.........123 Bridge St., Portland 48875
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London, John L...Lakeview Medical Ctr., Lakeview 48850
Marston, Leo L...............Box 235, Lakeview 48850
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O'Malley, R. J.................310 Main St., Ionia 48846
Pates, Don C............122 E. Congress, Belding 48809
Rice, Robt. E.........420 S. Bower St., Greenville 48838
Robertson, Perry C. (L)......327 Center St., Ionia 48846
Rottman, G. Jay....6413 N. Lafayette, Greenville 48838
Sanford, Louis E............219 Main St., Belding 48809
Slagh, Milton E.........................Saranac 48881
Smith, Robt. O..........910 E. Lincoln Ave., Ionia 48846
Socha, Edmund S..............217 E. Main, Ionia 48846
Stevens, Charles E...513 N. Lafayette St., Greenville 48838
Tannheimer, John F........525 Lafayette St., Ionia 48846
Younis, Ahmad.....505 S. Lafayette St., Greenville 48838

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Ahronheim, Gerald (M)..........TDY 6168th Air Base, APO San Francisco, Calif...96213
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Allen, Duane M.....Hanover Medical Ctr., Hanover 49241
Appel, Saul........112 W. Michigan Ave., Jackson 49201
Argun, Turan.....762 W. Michigan Ave., Jackson 49201
Baker, Geo. M...............350 S. Union, Parma 49269

Beckwith, Sidney A....100 E. Main St., Stockbridge 49285
Bentley, Jack P.....2532 Spring Arbor Rd., Jackson 49203
Bentley, Mary E. N., 2532 Spring Arbor Rd., Jackson 49203
Betts, Joseph S..52 Brigham St., New Bedford, Mass. 02741
Booth, Jerry B. DDS (A).........766 W. Michigan Ave., Jackson 49201
Brashares, Zane A.......................Brooklyn 49230
Bullen, G. R. (L)..........418 Third St., Jackson 49201
Buslepp, Robert C.....901 Reynolds Bldg., Jackson 49201
Celis, F. T.......766 W. Michigan Ave., Jackson 49201
Clarke, Corwin S. (L) Hacinda Carmel, Carmel, Ca. 93921
Cooley, Chas. W.............Mercy Hosp., Jackson 49201
Coriey, Cecil (L).....204 Homecrest Rd., Jackson 49201
Corley, Ennis H. (L)..1401 Reynolds Bldg., Jackson 49201
Corley, Robt. W......1401 Reynolds Bldg., Jackson 49201
Daly, Byrne M..........297 W. Michigan, Jackson 49201
Davenport, Bruce............612 First St., Jackson 49203
De May, Cuthbert E. (L).........403 E. Michigan Ave., Jackson 49201
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McLaughlin, Miar J. (L)..710 S. Brown St., Jackson 49203
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Michaud, A. J.........204 Homecrest Rd., Jackson 49201
Morelli, Lorenzo......401 W. Prospect St., Jackson 49203
Muhich, Ralph A...2532 Spring Arbor Rd., Jackson 49203
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Niekamp, Harold....762 W. Michigan Ave., Jackson 49201
Oleksy, Stanley P........744 W. Michigan, Jackson 49201
Olsen, Lloyd L.....610 W. Michigan Ave., Jackson 49201
Oster, Harold L...........1514 Fourth St., Jackson 49203
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Payne, Andrew K...Foote Memorial Hosp., Jackson 49201
Phillips, Geo. H...Jackson Co. T. B. Sanat., Jackson 49202
Pray, Frank F. (L)...........6533 Woodward Lake Rd., Fenwick 48834
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Rice, John W.............421 McNeal St., Jackson 49203
Ries, Richard G.......720 W. Franklin St., Jackson 49201
Riley, Philip A. (L)....500 S. Jackson St., Jackson 49203
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Rodriquez, Leopoldo..810 W. Saginaw St., Lansing 48915
Rua, Ignacio..............1810 W. High, Jackson 49203
Rucker, Joseph..........1012 Francis St., Jackson 49203
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Harrell, Frank G.........1602 Gull Rd., Kalamazoo 49001
Harrelson, Wm. D........1324 S. Park, Kalamazoo 49001
Hayner, Russell A........4015 Portage, Kalamazoo 49001
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Herendeen, Donald E....1219 S. Park, Kalamazoo 49001
Hersey, E. Freeman................1215 Oakland Drive, Kalamazoo 49001
Hersey, Margaret S...1215 Oakland Dr., Kalamazoo 49001
Hildreth, Roscoe C....458 W. South St., Kalamazoo 49006
Hodges, Ralph M.....1631 Gull Rd. 209, Kalamazoo 49001
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Hodgman, Richard W. 612 Douglas Ave., Kalamazoo 49007
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Hudson, A. Thomas..............1631 Gull Rd. #201, Kalamazoo 49001
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Taylor, Joseph L.................1033 Fulton St. West, Grand Rapids 49504
TenHave, John (L)............3515 Briggs Blvd. N.E., Grand Rapids 49505
TerKeurst, Donald H.............2740 Eastern Ave. S.E., Grand Rapids 49507
Tesseine, Arthur J..................1328 Madison S.E., Grand Rapids 49507
Teusink, James H...................Cedar Springs 49319
Theodore, Paul G.............1520 Plainfield Ave. N.E., Grand Rapids 49505
Thompson, Athol B. (L)..........1857 Golden Rain Rd., Walnut Creek, Ca. 94529
Thompson, Edward C...........153 Lafayette Ave. S.E., Grand Rapids 49503
Thompson, Frank D..........2008 El Dorado Dr. S.E., East Grand Rapids 49506
Tiffany, Jos. C................502 Medical Arts Bldg., Grand Rapids 49501
Tomatis, Luis A...456 Cherry St. S.E., Grand Rapids 49503

Torgerson, Wm. R.............Ramona Medical Center, Grand Rapids 49506
Townsend, Jack H...............515 Lakeside Dr. S.E., Grand Rapids 49506
Troske, Robt. L.......534 Dogwood Dr. N.E., Ada 49301
Truog, Clarence P...110 Fulton St. E., Grand Rapids 49502
Turcotte, V. J., Jr................515 Lakeside Dr. S.E., Grand Rapids 49506
Vaandrager, Vernon D...............245 State St. S.E., Grand Rapids 49502
Valdmanis, F.....2120 Lake Dr. S.E., Grand Rapids 49506
Van Bree, Raymond S................812 Rosalie N.W., Grand Rapids 49504
Van Dam, Forrest R..............1810 Wealthy St. S.E., Grand Rapids 49506
Vanden Berg, A. R. 833 Lake Dr. S.E., Grand Rapids 49506
Vandenberg, Wm...124 Fulton St. E., Grand Rapids 49502
Vanden Berg, Wm. O..............50 College Ave. S.E., Grand Rapids 49503
Vander Kolk, K. J...............2740 Eastern Ave. S.E., Grand Rapids 49507
Vander Meer, Raymond..........26 Sheldon Ave., S.E., Grand Rapids 49502
Vandermolen, John..124 Fulton St. E., Grand Rapids 49502
Vander Ploeg, R. A...............26 Sheldon Ave. S.E., Grand Rapids 49502
Vander Ploeg, Wm. H...............833 Lake Dr. S.E., Grand Rapids 49506
Van Der Veer, Corwin G.............245 State St. S.E., Grand Rapids 49503
Van Dommelen, G. M................245 State St. S.E., Grand Rapids 49502
Van Duine, Henry J.................153 Lafayette S.E., Grand Rapids 49503
Van Dyke, Harold E.............1108 Leonard St. N.E., Grand Rapids 49503
Van Etten, Donald D. (A)..Box 1, Bahrain, Arabian Gulf
Van Goor, Kornelius..............26 Sheldon Ave. S.E., Grand Rapids 49502
Van Nuis, Cornelis...................245 State St., S.E., Grand Rapids 49502
Van Otteren, G. F...................245 State St. S.E., Grand Rapids 49502
Van Portfliet, Paul..245 State St. S.E., Grand Rapids 49502
VanSolkema, Andrew A..............953 E. Fulton St., Grand Rapids 49503
Van't Hof, Albert.................50 College Ave. S.E., Grand Rapids 49503
Van Vliet, Peter D..............100 Michigan St. N.E., Grand Rapids 49503
Van Woerkom, Danl..............933 Leonard St. N.W., Grand Rapids 49504
Van Zwalenburg, B. R...........2116 Coronado Dr. S.E., Grand Rapids 49506
Vasu, C. Mark..833 Lake Drive S.E., Grand Rapids 49506
Veldman, Harold E. (L)..............26 Sheldon Ave., Grand Rapids 49502
Veltman, Jay H.......3946 G 30th St., Grandville 49418
Venema, Jay R...............540 Overbrook Lane S.E., Grand Rapids 49507
Ver Lee, Jimmie J. (A)................Galmi Hospital, Galmi Via Madaoua, Niger Republic, West Africa
Ver Meulen, John (L)..........2501 Central Ave. S.W., Grand Rapids 49509
Ver Meulen, Peter (A)..............105 Baynton N.E., Grand Rapids 49503
Verwys, A. L. Hubert................815 Alger St. S.E., Grand Rapids 49507
Vining, Keats K., Jr..............515 Lakeside Dr. S.E., Grand Rapids 49506
Vis, William R. (L)..............26 Sheldon Ave. S.E., Grand Rapids 49502
Visscher, H. C. 515 Lakeside Dr. S.E., Grand Rapids 49506
Visscher, Robert D.............515 Lakeside Drive S.E., Grand Rapids 49506
Visser, Earl R................530 Overbrook Lane S.E., Grand Rapids 49507
Vogel, Anton..................1204 Madison Ave. S.E., Grand Rapids 49507
Volkel, James S..................833 Lake Drive S.E., Grand Rapids 49506
Voss, John A...................2410 Gaynor Ave. N.W., Grand Rapids 49504
Vroon, John....50 College Ave. S.E., Grand Rapids 49503
Vyn, Jay D. (L) 7119 Driftwood S.E., Grand Rapids 49506
Wahby, Elmer F.................100 Michigan St. N.E., Grand Rapids 49503
Walma, Daniel................26 Sheldon Avenue S.E., Grand Rapids 49502
Wassink, Roger N................26 Sheldon Ave. S.E., Grand Rapids 49502
Waterman, Donald F............515 Lakeside Dr. S.E., Grand Rapids 49506
Watkins, James K.................26 Sheldon Ave. S.E., Grand Rapids 49502
Webb, Clarence F. 833 Lake Dr. S.E., Grand Rapids 49503
Webber, Jerome E.................50 College Ave. S.E., Grand Rapids 49503
Weeber, Thomas A...3011 Wilson S.W., Grandville 49418
Wehrenberg, R. A. (A)..........Pleasure Bay, Apt. 5, Long Branch, N.J. 07740
Weller, Keith E.................1200 Lake Drive S.E., Grand Rapids 49506
Wendt, Vernon E..................937 Fulton St. W., Grand Rapids 49504
Westendorp, Floyd...............6850 Division Ave. S., Grand Rapids 49508
Westerhoff, Robert J.................808 Alger St. S.E., Grand Rapids 49507
Whinery, Jos. F. 50 College Ave. S.E., Grand Rapids 49503
Whitehouse, John D............1201 Colorado Ave. S.E. Grand Rapids 49506
Whittenberger, R. N.................245 State St. S.E., Grand Rapids 49502
Wiese, John L...50 College Ave. S.E., Grand Rapids 49503
Wilcox, Rex G. (A)..........1045 Keneberry Way S.E., Grand Rapids 49506
Wilderom, Morris...............1619 Walker St. N.W., Grand Rapids 49504
Wilkes, John B................1328 Madison Ave. S.E., Grand Rapids 49507
Wilkinson, C. A.................2030 Leonard St. N.W., Grand Rapids 49504
Williams, John R...833 Lake Dr. S.E., Grand Rapids 49506
Wilson, John R. 1033 Fulton St. West, Grand Rapids 49503
Wilson, Robert J...1011 Fulton St. E., Grand Rapids 49503
Winfield, Emery D. (L)..............457 Burton S.E., Grand Rapids 49507
Winter, Garrett E.............1967 Godfrey Ave. S.W., Grand Rapids 49509
Wright, Thos B. (A)..........2614 Plainfield Ave. N.E., Grand Rapids 49505
Wurz, John F..................201 Norwood Ave. S.E., Grand Rapids 49506
Wyngaarden, Martin K..............245 State St. S.E., Grand Rapids 49503
Yared, Jerome A...651 Cherry St. S.E., Grand Rapids 49506
Yost, William G., Jr...............50 College Ave. S.E., Grand Rapids 49503
Young, Donald G...............100 Michigan St. N.E., Grand Rapids 49503
Zadvinskis, Z.....833 Lake Dr. S.E., Grand Rapids 49506
Zimmerman, Wm. G..............26 Sheldon Ave. S.E., Grand Rapids 49502
Zwemer, Rodger J..............1810 Wealthy St. S.E., Grand Rapids 49506

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M....Lapeer State Home, Lapeer 48446
Berker, Isak O..............South Street, Davison 48423
Bishop, G. Clare.........................Almont 48003
Boruch, Leon R...........834 Liberty St., Lapeer 48446
Conaway, Chas. E........1257 N. Main St., Lapeer 48446
Dorland, Clarke...........221 Lincoln St., Lapeer 48446
Doty, James R...............315 Clay St., Lapeer 48446
Greavu, Cornell, Jr.................North Branch 48461

Grunawalt, Robert E. (A) 821 Madison St., Lapeer 48446
Haney, M. Bennet.....409 E. St. Clair St., Almont 48003
Heitsch, Wm. C.........3257 Davison Rd., Lapeer 48446
House, Clifford............1750 Grey Rd., Lapeer 48446
Kiehler, E. G., II........3257 Davison Rd., Lapeer 48446
Kim, S. J...............4462 Thorntree Dr., Flint 48506
Kocur, Lubomira...............Drawer A, Lapeer 48446
Lebedovych, Emil............Drwr. A, Lapeer S. Home, Lapeer 48446
Lebedovych, Ksenia.........Drawer A, Lapeer S. Home, Lapeer 48446
Leith, Dorothy L.........240 Main St., Imlay City 48444
Lopez, Leonardo V. (A)....295 W. Huron, Pontiac 48053
Lynk, Stanley M..........4589 Lippincott, Lapeer 48446
Smith, Ellen (A)..................400 White Rd., R. 1, Columbiaville 48421
Smith, Glenn L.....6552 Imlay City Rd., Imlay City 48444
Ucer, Erol (A).......2835 W. Genesee St., Lapeer 48446
Zemmer, H. R...............N. Main St., Lapeer 48446
Zolliker, Carl R. (R)......3646 Slattery Rd., Lum 48452

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O........................Hudson 49247
Allen, Russell A.......415 W. Maumee St., Adrian 49221
Armovit, Herminio........236 S. Fourth St., Onsted 49265
Bachman, Joseph F.............602 E. Pottawatamie St., Tecumseh 49286
Balice, F. W.............128 E. Butler St., Adrian 49221
Baylon, Leonardo.........231 N. Main St., Adrian 49221
Benz, Carl A.............308 N. Broad St., Adrian 49221
Berghuis, John.........225 Riverside Ave., Adrian 49221
Blanchard, Lowell E.....................Hudson 49247
Blanden, Merwin R...................Tecumseh 49286
Boyd, James W.......4510 Southgate Lane, Adrian 49221
Burch, Larry T...........10 Cairns St., Tecumseh 49286
Coak, Richard D...............602 E. Pottawatamie St., Tecumseh 49286
Conner, Edward D..........3 Scott Court, Adrian 49221
Cook, Carlton L....603 E. Pottawatamie, Tecumseh 49286
Cooper, James H..........308 N. Broad St., Adrian 49221
Diccion, R. A..........................Morenci 49256
Dickman, Harry M...........104 Oak St., Hudson 49247
Dustin, Richard E.....103 W. Brown St., Tecumseh 49286
Eddy, Howard R. C.............Mill Rd., Adrian 49221
Feeney, James L.................Mill St., Adrian 49221
Galliani, M............4410 Evergreen Dr., Adrian 49221
Gamble, Kenneth.................R. 3, Hudson 49247
Gascoigne, Richard H. (M)..........693 Stockford Dr., Adrian 49221
Gilkey, William C.....693 Stockford Drive, Adrian 49221
Gilmartin, Richard................Mill St., Adrian 49221
Greiner, Robert A........Professional Bldg., Adrian 49221
Hamilton, John..................Mill St., Adrian 49221
Hamilton, Thomas........113 W. Front St., Adrian 49221
Hammersley, Gordon.....1361 Oregon Rd., Adrian 49221
Harrison, Robt. E.........418 W. Adrian, Blissfield 49228
Heffron, Chas H...........231 N. Main St., Adrian 49221
Heffron, C. Harold (L)....231 N. Main St., Adrian 49221
Heffron, Howard H........231 N. Main St., Adrian 49221
Helzerman, Ralph F...112 S. Ottawa St., Tecumseh 49286
Hewes, Wm. H..................Mill Rd., Adrian 49221
Hunt, Philip.....................Mill St., Adrian 49221
Locke, Francis A.............755 High St., Adrian 49221
Marsh, Roland G. B. (L)..............1938 Spruce St., Boulder, Co. 80302
Marshall, Mary L....1389 W. Maple Ave., Adrian 49221
Miller, P. Lynford..............GMC Fisher Body Div., 5550 Occidental Hwy., Tecumseh 49286
Ocamb, Harold D...600 E. Pottawatamie, Tecumseh 49286
Parker, Donald A...........Bixby Hospital, Adrian 49221
Patmos, Bernard........127 E. Maumee St., Adrian 49221
Phelan, Alvin J...............10 Cairns, Tecumseh 49286
Purfield, Wm. P....................Manchester 48158
Quadros, Everton......................Blissfield 49228
Raabe, Elmer C.......................Morenci 49256
Richey, Bert R.....765 Manitou Rd., Manitou Beach 49253
Sarapo, Donato F.................Mill St., Adrian 49221
Shannon, Gordon (A).................Blissfield 49228
Skufis, Eleanor P.........201 Orchard Rd., Adrian 49221
Skufis, Xenophon.........123 E. Chestnut, Adrian 49221
Stewart, Landis C............750 High St., Adrian 49221
Taylor, Richard L.......Emma Bixby Hosp., Adrian 49221
Van Dusen, Chad A. (L).......R.F.D. 5, Blissfield 49228
Wentz, Patricia.............760 Riverside, Adrian 49221
White, Robert B.............945 Riverside, Adrian 49221
Whitehouse, Keith H....................Morenci 49256
Wilson, Geo. C.................Box 224, Clinton 49236
Wolf, Marvin B..........689 Stockford Dr., Adrian 49221
Wynn, Geo. H...........1115 W. Maumee, Adrian 49221

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A..........116 N. Michigan, Howell 48843
Clarke, Niles A......116 W. Grand River, Brighton 48116
Damstra, Donald L. 12893 E. Grand River, Brighton 48116
Duffy, Ray M. (L)........P.O. Box 106, Pinckney 48169
Granowski, Karol..........McPherson Comm. Hlth. Ctr., Howell 48843
Harebottle, Norman H.............25 W. University Dr., Tempe, Arizona 85281
Hauer, R. Fred......................Fowlerville 48836
Hendren, Jesse J. (R)................Fowlerville 48836
Higby, Thomas F.....................Fowlerville 48836
Hill, Harold C.......116 N. Michigan Ave., Howell 48843
Hoffman, Stanley L.......1200 Byron Road, Howell 48843
May, Louis E...............City Route 4, Howell 48843
Perry, Florence J. C..............17640 San Rose Ave., Lathrup Village 48075
Phillips, R. W.........................Hamburg 48139
Polack, Robt. T........1225 Lakeside Dr., Howell 48843
Schenden, A. J. (R)......2753 Page St., Ann Arbor 48104
Schmitt, Phillip E......515 So. Tompkins, Howell 48843
Sheng, Luke H. C....111 W. Grand River, Brighton 48116
Stuber, Roscoe V..........1200 Byron Rd., Howell 48843
Walker, Enos G......4485 Cordley Lake, Lakeland 48143
Wang, Stella K. C.......111 Grand River, Brighton 48116
Woodworth, Edwin S......1200 Byron Rd., Howell 48843

LUCE COUNTY MEDICAL SOCIETY (122)

Barstow, Donald K....................Engadine 49827
Dale, Edward C...............Box 9, Newberry 49868
Eadie, Gordon A.,........East Upper Pen. Health Dept., Newberry 49868
Gibson, Robert D...804 Newberry Ave., Newberry 49868
Gibson, Robt. E. L., Jr...207 W. John St., Newberry 49868
Grennan, Lawrence E. (A)........1344 Northlawn N.E., Grand Rapids 49505
Hicks, R. P.............210 W. John St., Newberry 49868
Kearney, Martin J.............118 Brewer Dr., Apt. 14A, Battle Creek 49015
Keizer, B. G.......Newberry State Hosp., Newberry 49868
Margoles, Milton..Newberry State Hosp., Newberry 49868
Purmort, Wm. R., Jr.............Newberry State Hosp., Newberry 49868
Thompson, Thos. W. (L)...........Route 2, Rox 691M, Traverse City 49684

MACOMB COUNTY MEDICAL SOCIETY (126)

Alejos, Juan E..........276 43 Schoenherr, Warren 48093
Alexander, James H...25815 Harper, St. Clair Shores 48081
Alvarez, Mercedes..11686 Eleven Mile Rd., Warren 48093
Ambrose, Robt. H. 18801 E. Ten Mile Rd., Roseville 48066
Arellano, Miguel A......21500 Mound Rd., Warren 48091
Audretsch, F. E...........355 Lincoln, Grosse Pte. 48230
Averbuch, Fred, Maj., MC (A)......USAF Hosp., APO, San Francisco, Ca. 96323
Barker, John G.....8050 Warren Blvd., Center Line 48015
Beecher, Alvin J.........21501 Kelly, East Detroit 48021
Bigley, Bernard........35992 Gratiot, Mt. Clemens 48043
Biluk, Frank J..........GM Tech. Center, Warren 48092
Bishai, Yousef B. 11477 E. Twelve Mile Rd., Warren 48093
Blain, Donald G......198 S. Gratiot, Mt. Clemens 48043
Bond, Franklyn F...4861 E. Nine Mile Rd., Warren 48091
Bower, Allen B. (L)....................Armada 48005
Brown, Leland C....21536 Parkway, St. Clair Shores 48082
Bryce, James W..24735 Van Dyke Ave., Center Line 48015
Bulcourf, Carlos J......31170 Hoover Rd., Warren 48093
Carruthers, W. B.......198 S. Gratiot, Mt. Clemens 48043
Chabator, George........294 Benjamin St., Romeo 48065
Charbeneau, Harold P...229 S. Gratiot, Mt. Clemens 48043
Charbonier, Luis M...........11868 E. Eleven Mile Rd., Warren 48089
Clay, Joel W.......263 S. Gratiot Ave., Mt. Clemens 48043
Cohen, Alan.......12500 Twelve Mile Rd., Warren 48093
Cohen, Alberto.....25705 Stonycroft Dr., Southfield 48075
Colah, Sorab A.................708 Monitor Leader Bl., Mt. Clemens 48043
Collon, David (A) D.D.S..................Romeo 48065
Corbett, John.........225 S. Gratiot, Mt. Clemens 48043
Cosio, Jose.......St. Joseph Hospital, Mt. Clemens 48043
Croman, Jos. M., Jr. (R)...............131 Market St., Mt. Clemens 48043
Curatolo, Victor......67 Cass Ave., Mount Clemens 48043
Danan, Bernardo M..11477 E. 12 Mile Rd., Warren 48089
Darian, H. B........11528 E. 12 Mile Rd., Warren 48093
Deal, Harold R..........23700 Van Dyke, Warren 48089
Deocampo, E.......20720 Maxine, St. Clair Shores 48080
Deocampo, Nestor D.............11477 Twelve Mile Rd., Warren 48093
Depaulis, Dario C........22770 Kelly, East Detroit 48021
Dilone, Polibio A.....493 W. Grand Blvd., Detroit 48216
Dionne, Paul........8216 E. 12 Mile Rd., Warren 48093
Dudzinski, Edmund J...............424 Washington St., New Baltimore 48047
Ebner, Charles M..................25520 Little Mack, St. Clair Shores 48081
Ekelman, Seymour B.....14 Belleview, Mt. Clemens 48043
Ellias, Elmer P..........23700 Van Dyke, Warren 48089
Engels, John A..........69311 N. Main, Richmond 48062
Erkfitz, Arthur W.....RR# 2 Crabapple Rd., c/o R. E. Smith, Roswell, Ga. 30075
Eyl, Thomas B..........66704 Van Dyke, Romeo 48065
Fagelman, Jerry S...........27841 Adler, Warren 48093
Finn, James Wm...............46056 Cass, Utica 48087
French, Lawrence W.....................25815 Harper, St. Clair Shores 48081
Friedman, Herbert F............13087 Eleven Mile Rd., Warren 48093
Fulgenzi, Andrew A............17301 E. Eight Mile Rd., East Detroit 48021
Gerbasi, Francis...................81 Lochmoor Blvd., Grosse Pte. Shs. 48236
Gesser, Charles................17800 E. Eight Mile Rd., Harper Woods 48236
Goldin, Morris I.........6902 Chicago Rd., Warren 48092
Goldman, Bernard J.................243 S. Gratiot Ave., Mt. Clemens 48043
Gonzalez, C. G.........20 Parkview, St. Joseph Hospital, Mt. Clemens 48043
Haas, Michael.......................20867 Mack Ave., Grosse Pte. Wds. 48236
Hahne, Otto H...8425 E. Twelve Mile Rd., Warren 48093
Hartmann, Waldemar B.................1416 S. Gratiot, Mount Clemens 48043
Hiller, Herbert M.............13500 E. Twelve Mile Rd., Warren 48093
Hirzel, Leon S..............33080 Garfield, Fraser 48026
Horvath, Julius........18847 Rosetta, East Detroit 48021
Hoski, Joseph A...8425 E. Twelve Mile Rd., Warren 48093
Hranchook, Michael......30001 Van Dyke, Warren 48093
Hull, Frank J....728 Canterbury, Grosse Pte. Woods 48236
Iacobelli, Claudio M..................22745 Kelly Rd., East Detroit 48021
Iglesias, Ernesto R.............608 Monitor Leader Bl., Mt. Clemens 48043
Isaacs, Eli M..........14230 Greenbriar, Oak Park 48237
Isbey, Edward K...........28494 Hoover, Warren 48093
Jacobs, Manuel......23700 Van Dyke Ave., Warren 48089
Jewell, James H...Roseville Theatre Bldg., Roseville 48066
Kane, John P.........67 Cass Ave., Mount Clemens 48043
Kane, Peter V.....230 North Ave., Mount Clemens 48043
Kane, Wm. J. (L)..171 North Avenue, Mt. Clemens 48043
Katzman, Harold L...13500 E. 12 Mile Rd., Warren 48093
Key, Robin S..........28495 Hoover Rd., Warren 48093
Kingsley, Joyce W., Jr...............18801 Ten Mile Rd., Roseville 48066
Kipp, Paul R...........14 Belleview, Mt. Clemens 48043
Kirtland, Wm. B., Jr.............18801 E. Ten Mile Rd., Roseville 48066
Klein, Alfred A..........23700 Van Dyke, Warren 48089
Knoblauch, K. H...8425 Twelve Mile Rd. E., Warren 48093
Kokeny, Wm. J.....23700 Van Dyke Ave., Warren 48093
Kommel, Richard M....................26510 Dundee, Huntington Wds. 48070
Krieger, Bruce..............15250 Park, Oak Park 48237
Krieger, Harvey A...13500 12 Mile Rd. E., Warren 48093
Kripke, Morton J............11255 Hall Rd., Utica 48087
Kroon, Joseph D...............656 Wellington Crescent, Mt. Clemens 48043
Kuntzman, Carl E....134 University Dr., Rochester 48063
Kurtz, Hyman..........16712 Timberview, Fraser 48026
Kypros, George P...................25520 Little Mack, St. Clair Shores 48081
Lapp, Charles.............7817 McClellan, Utica 48087
Lee, Lawrence E. 8425 E. Twelve Mile Rd., Warren 48093
Lee, Thomas E......13403 E. 13 Mile Rd., Warren 48093
Levi, Charles....8262 E. Twelve Mile Rd., Warren 48093
Licata, Samuel A.....21349 Kelly Rd., East Detroit 48021
Llaneza, Onofre B..................21420 Harper Ave., St. Clair Shores 48080
Loo, Rodolfo V.............1664 Witherbee, Troy 48084
Lopez, Gerald L....25660 Lexington Lane, Roseville 48066
Lubera, Richard J...................25520 Little Mack, St. Clair Shores 48081
Lublin, Ann.............5224 St. Antoine, Detroit 48202
Maguire, Andrew J.........45569 Van Dyke, Utica 48087
Marcuz, Edo V.............11255 Hall Rd., Utica 48087
Marinelli, Ralph..8252 E. Twelve Mile Rd., Warren 48093
Mark, Hansi.........8236 E. 12 Mile Rd., Warren 48093
Martin, Wm. L............117 S. Main St., Romeo 48065
Mattes, Max W..........18456 Wildemere, Detroit 48221
Matthews, C., Jr.........14 Belleview, Mt. Clemens 48043
Maxim, Edward S.......225 S. Gratiot, Mt. Clemens 48043
Mayer, Mary L......715 S. Rogers, Apt. 19, Mason 48854
McGinty, John D......243 S. Gratiot, Mt. Clemens 48043
McMorrow, Kathryn........28526 Hoover, Warren 48093
Merametdjian, Krikor....22841 Van Dyke, Warren 48089
Merritt, Jule J...36640 S. Gratiot Ave., Mt. Clemens 48043
Messmer, Harold O..........7817 McClellan, Utica 48087
Meyers, Sidney S...........28477 Hoover, Warren 48093
Miller, Sidney S.........28477 Hoover Rd., Warren 48093
Moore, Geo. F. (L)....69434 N. Forest, Richmond 48062
Morris, Gerald W.......14 Belleview, Mt. Clemens 48043
Mulligan, Philip T...............612 Monitor Leader Bl., Mount Clemens 48043
Nance, Marion E..........P.O. Box 157, Weidman 48893
Nutting, Helen M.................22631 Greater Mack, St. Clair Shores 48080
Ornstein, Chas.......21701 Kelly Rd., East Detroit 48021
O'Shee, Vincent..8216 E. Twelve Mile Rd., Warren 48093
Oughtred, Orville....26401 Harper, St. Clair Shores 48081
Pacho, Marc..........25786 Cambridge, Roseville 48066
Paris, Delmo A....18801 E. Ten Mile Rd., Roseville 48066
Parmelee, N. H.......50551 Van Dyke Ave., Utica 48087
Parnagian, Leo........14 Belleview, Mt. Clemens 48043
Perez, Florence........25786 Cambridge, Roseville 48066

Porretta, Anthony C..................2112 Venier Rd., Grosse Pte. Wds. 48236
Pugliesi, Frank J.....20927 Kelly Rd., East Detroit 48021
Ragheb, Moufid...............705 N. Valley Chase Rd., Bloomfield Hills 48013
Rakotz, Gerald....13087 Eleven Mile Rd., Warren 48093
Ramos, Antonio E.......29846 Schoenherr, Warren 48093
Reitzel, Rufus H..................199 S. Gratiot Ave., Mount Clemens 48043
Revere, Jos. O...192 S. Gratiot Ave., Mount Clemens 48043
Riddle, Charles B...............620 Eastland Prof. Bld., Harper Woods 48236
Rinkenberger, E. A.................243 S. Gratiot Ave., Mt. Clemens 48043
Rivkin, Jos...........14 Belleview, Mount Clemens 48043
Rooney, Robert..........23700 Van Dyke, Warren 48089
Roth, Geo. E.........19136 Mendota Ave., Detroit 48221
Rothman, Arthur M................22422 Gratiot Ave., East Detroit 48021
Rourke, Ronald E..................21503 Harper Ave., St. Clair Shores 48080
Rousseau, Daniel L...............Monitor Leader Bldg., Mt. Clemens 48043
Rush, Wm. E.............St. Johns Hosp., Detroit 48236
Russell, Paul..........198 S. Gratiot, Mt. Clemens 48043
Ryan, Jack.........23700 Van Dyke Ave., Warren 48089
Ryan, Thomas E.....39310 Gary Ave., Mt. Clemens 48043
Salot, Russell F.......67 Cass Ave., Mount Clemens 48043
Sarnacki, Carl J...8425 Twelve Mile Rd. E., Warren 48093
Scher, Jos. N.......130 Cass Ave., Mount Clemens 48043
Scher, Sydney.......132 Cass Ave., Mount Clemens 48043
Schmunk, Robert F...136 Cass Avenue, Mt. Clemens 48043
Setter, Thomas J.....16214 Chatham Drive, Fraser 48026
Shawky, Yehya A. 8425 E. Twelve Mile Rd., Warren 48093
Shaya, Ezra S..............31170 Hoover, Warren 48093
Sheppard, Lawrence F............23700 Van Dyke Ave., Warren 48089
Sherbin, Herbert D.............12500 Twelve Mile Rd., Warren 48093
Sherman, Gerald......12500 12 Mile Rd., Warren 48093
Siegfried, Edward G...............229 S. Gratiot Ave., Mt. Clemens 48043
Silverman, M. P.......28477 Hoover Road, Warren 48093
Simmons, Milton F...........12500 E. Twelve Mile Rd., Warren 48093
Sims, Wm. N........229 S. Gratiot, Mount Clemens 48043
Singer, Nelson.....22100 Gratiot Ave., East Detroit 48021
Stanton, James........225 S. Gratiot, Mt. Clemens 48043
Starbird, Wm. A.........8216 E. 12 Mile, Warren 48093
Starkman, Morris..........28477 Hoover, Warren 48093
Steele, George H.......229 S. Gratiot, Mt. Clemens 48043
Steinberger, Eugene.....23700 Van Dyke, Warren 48089
Stepka, Joseph E..........50551 Van Dyke, Utica 48087
Stief, Kirwin..218 N. Christine Circle, Mt. Clemens 48043
Stone, Julius..........198 S. Gratiot, Mt. Clemens 48043
Stoyka, Charles.....21503 Harper, St. Clair Shores 48080
Stroude, Donald E. (A) D.D.S.....8425 Twelve Mile Rd., Warren 48093
Stryker, Oscar D. (L)..............38422 Hidden Lane, Mt. Clemens 48043
Sturm, Fredk. A.........76 Lochmoor, Grosse Pte. 48236
Suksta, Adolph W......23350 Gratiot, East Detroit 48021
Suzuki, M...............23700 Van Dyke, Warren 48089
Thompson, Alfred A. 126 Cass Ave., Mount Clemens 48043
Tinkey, L. Leo.....8306 Twelve Mile Rd., Warren 48093
Transue, David (M)..13403 E. 13 Mile Rd., Warren 48093
Tucker, Kenneth F.......23700 Van Dyke, Warren 48089
Urbancic, William......22048 Gratiot, East Detroit 48021
Watts, Fredric.........27440 Hoover Rd., Warren 48093
Weinberger, K. A...27643 Schoenherr Rd., Warren 48093
Weiss, Jack I.......23700 Van Dyke Ave., Warren 48089
Whitley, Alec....21707 Erben Dr., St. Clair Shores 48081
Wilde, Maurice M...........5930 Chicago, Warren 48092
Wilson, Norman R. 225 S. Gratiot Ave., Mt. Clemens 48043
Witus, Carl..........21349 Kelly Rd., East Detroit 48021
Wolf, Ervin......Roseville Theatre Bldg., Roseville 48066
Wyte, Wm. C.....263 S. Gratiot Ave., Mt. Clemens 48043
Yamasaki, Ken..........23700 Van Dyke, Warren 48089
Zager, Bernard S...4133 Mattos Dr., Fremont, Calif. 94536
Zavela, Dan......679 N. Renaud, Grosse Pte. Wds. 48236
Zink, Robert A.....................25815 Harper Ave., St. Clair Shores 48081
Zook, Mr. Gilbert E. (A)...............253 S. Gratiot, Mt. Clemens 48043
Zotovas, Alex..........23700 Van Dyke, Warren 48089

MANISTEE COUNTY MEDICAL SOCIETY (130)

Custer, Harry R........723 Park Ave., Charlevoix 49720
Futterer, LeRoy A.....Forest Clinic Bldg., Manistee 49660
Garneau, Robt. R.....Forest Clinic Bldg., Manistee 49660
Hansen, Ernest C...........326 First St., Manistee 49660
Kellawan, Karl K..........Forest Clinic, Manistee 49660
Konopa, John F............57 Poplar St., Manistee 49660
Miller, Ernest B............326 First St., Manistee 49660
Paterson, Roger............310 9th St., Manistee 49660
Ramsdell, Homer A. (L)...398 River St., Manistee 49660
Rosenow, K. G........Forest Clinic Bldg., Manistee 49660
Schwing, Donald N...Forest Clinic Bldg., Manistee 49660
Wild, David A............84 Cypress St., Manistee 49660

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Acocks, James R...Morgan Hgts. Sanat., Marquette 49855
Amolsch, Arthur L. (L)..1008 Bluff St., Marquette 49855
Beaghler, R. L.................St. Lukes Hosp., Path., Marquette 49855
Bennett, Matthew C..............1414 W. Fair Avenue, Marquette 49855
Berry, Robt. F....1414 W. Fair Avenue, Marquette 49855
Bertucci, Jos. P.........114 S. First St., Ishpeming 49849
Bolitho, Thos. B...1414 W. Fair Avenue, Marquette 49855
Brish, Adam........1414 W. Fair Ave., Marquette 49855
Bujard, Robert S.....1414 W. Fair Ave., Marquette 49855
Carefoot, Rankin L..............1414 W. Fair Avenue, Marquette 49855
Casler, Wilbur L. (L)..131 E. Ridge St., Marquette 49855
Celori, Luciano.........427 W. College, Marquette 49855
Conley, Donal T...1414 W. Fair Avenue, Marquette 49855
Cooperstock, Moses..1414 W. Fair Ave., Marquette 49855
Corcoran, Wm. A. (L)..............200 S. Main Street, Ishpeming 49849
Elzinga, Donald R...1414 W. Fair Ave., Marquette 49855
Elzinga, Eugene R...............1414 W. Fair Avenue, Marquette 49855
Emani, Firooz......1414 W. Fair Ave., Marquette 49855
English, John W...1414 W. Fair Avenue, Marquette 49855
Flores, R...............613 Lake St., Marquette 49855
Green, Southgate J.......................Gwinn 49843
Hopkins, William F...............1414 W. Fair Avenue, Marquette 49855
Hornbogen, Danl. P...............1414 W. Fair Avenue, Marquette 49855
Howe, Lloyd W. (L)..............Savings Bank Bldg., Marquette 49855
Huffman, Elston R...............1414 W. Fair Avenue, Marquette 49855
Humphrey, William C...829 Croix Street, Negaunee 49866
Jaedecke, Robt. G...........829 Croix, Negaunee 49866
Kane, Elizabeth D. (R)..............418 W. Magnetic, Marquette 49855
Koenig, Harry......540 E. Division St., Ishpeming 49849
Kronschnabel, E. F...............1414 W. Fair Avenue, Marquette 49855
Kublin, John C.......1414 W. Fair Ave., Marquette 49855
Lambert, Warren C....347 E. Ridge St., Marquette 49855
Lexmond, M. J........524 Mather Ave., Ishpeming 49849
Lincke, E. T......1414 W. Fair Avenue, Marquette 49855

Lyons, Barbara E...Student Hlth. Ctr., Northern Mich. Univ., Marquette 49855
Lyons, James W.........803 N. 3rd St., Marquette 49855
Matthews, Norman L.............N. Mich. Child Clinic, Marquette 49855
Morris, John C......401 29th Street, Oakland, Calif. 94609
Mudge, Thomas J...1414 W. Fair Avenue, Marquette 49855
Mudge, Wm. A. (L).....108 Ridge St., Negaunee 49866
Narotzky, Archie S.......Miracle Circle, Ishpeming 49849
Newell, Wilson G........101 S. Fourth, Ishpeming 49849
Niemi, Osmo (R)................Box 151, Gwinn 49843
Oldham, Earle S....427 W. College Ave., Marquette 49855
Olson, Walter R.........Sand Point Rd., Munising 49862
Pearson, Wallace G...............1414 W. Fair Avenue, Marquette 49855
Pillote, Florence A.....26 Lakeview Dr., Marquette 49855
Pillote, John F.....1414 W. Fair Avenue, Marquette 49855
Potter, Richard..........P.O. Box 790, Marquette 49855
Rosenbaum, Louis......524 Mather St., Ishpeming 49849
Sabin, Fredk. C...1414 W. Fair Avenue, Marquette 49855
Schmidt, Merle C. (A)................111 W. 39th St., Vancouver, Wa. 98660
Schroeder, W. Gene (M)................524 Mather St., Ishpeming 49849
Schweinsberg, Sara K. D. (A)....507 Bemis Rd. R.F.D., Saline 48176
Tobin, James F., Jr.........724 Elliott, Ishpeming 49849
Van Riper, Paul (L)..................Champion 49814
Wall, David R.......Aitamont & Fisher, Marquette 49855
Williams, Reginald G....524 Mather St., Ishpeming 49849
Wilson, George M., Jr.............1414 W. Fair Avenue, Marquette 49855
Wright, Kenneth C...............1414 W. Fair Avenue, Marquette 49855

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr.......101 N. Main, Scottville 49454
Boon, A. Floyd..........203 N. Ferry, Ludington 49431
Carney, John R........202 N. Park St., Ludington 49431
Carney, Ruth V. C....202 N. Park Ave., Ludington 49431
Castellani, R. J...........P.O. Box 349, Ludington 49431
Clark, Harry L. (L)..............510 N. Lakeshore Dr., Ludington 49431
Craymer, Austin..........420 N. Rath, Ludington 49431
Ewing, R. L.........600 Tinkham Ave., Ludington 49431
Hoffman, Howard B. 7418 Golfwood Rd., Ludington 49431
Irick, Robert..........Memorial Hosp., Ludington 49431
Kleinschmidt, Gladys J...........401 E. Ludington Ave., Ludington 49431
Martin, Wm. S..........107 Ludington, Ludington 49431
Mayer, Gerry..............806 Russell, Ludington 49431
Morrow, Wm. J.......2511 Elm Ave., Evanston, Il. 60201
Ostrander, Robt. A............5000 E. Grand Rd., #5, Tucson, Az. 85716
Paukstis, Chas. A.......111 E. Court St., Ludington 49431
Ramsey, John........119 N. James St., Ludington 49431
Sutter, Wm. F.........220 S. James St., Ludington 49431
Waun, James.........506 E. Ludington, Ludington 49431

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Asplund, Charles M.......213 Elm St., Big Rapids 49307
Bruggema, Jacob.................Main St., Evart 49631
Davis, Roy A......Ferris State College, Big Rapids 49307
Haldeman, Jack......1014 S. State St., Big Rapids 49307
Hickox, Leland A.....1014 S. State St., Big Rapids 49307
Kilmer, Paul B..........102 W. Upton, Reed City 49677
Kowaleski, Edward H....................Remus 49340
Lincoln, Norman V.......108 E. Upton, Reed City 49677
Merlo, Frank A.....206 S. Michigan St., Big Rapids 49307
Moon, Wm. W................Box 175, Baldwin 49304
Nelson, Lorenzo R............R. F. D. 1, Baldwin 49304
Phelps, Leland B.....111 S. Chestnut St., Reed City 49677
Price, Leonard....Ferris State College, Big Rapids 49307
Pusczak, George B........213 Elm St., Big Rapids 49307
Tyson, James L...1014 South State St., Big Rapids 49307
Van Auken, Edward W...229 S. Warren, Big Rapids 49307
Veenschoten, Girard.......380 South St., Baldwin 49304
Walters, James E.....1014 S. State St., Big Rapids 49307
White, John A.....121 S. Michigan St., Big Rapids 49307

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O..........531 1st St., Menominee 49858
Brukardt, Herman R......534 First St., Menominee 49858
Dewane, Francis J......413 10th Ave., Menominee 49858
Glickman, L. Grant......958 First St., Menominee 49858
Gonty, Arthur..St. Joseph Lloyd Hosp., Menominee 49858
Heidenreich, John R.....................Daggett 49821
Hopson, George H. (A)............19186 Santa Barbara, Detroit 48221
Hopson, Patricia C. (A)...........19186 Santa Barbara, Detroit 48221
Jones, Wm. S. (L)....1146 Tenth Ave., Menominee 49858
Jones, Wm. S., Jr......1146 10th Ave., Menominee 49858
Kerwell, Karm C. (L)....P. O. Box 17, Stephenson 49887
Strefling, John (O)..................Stephenson 49884
Towey, John W. (L)................1717 Orchid Lane Middleton, Wi. 53562

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Baker, Ophelia P...936 W. Houghton, West Branch 48661
Baker, Thomas A...936 W. Houghton, West Branch 48661
Blaha, Vernon B........................Grayling 48738
Boehm, John D. (R)..State Hospital, Traverse City 49684
Bontrager, W. E..........................Mio 48647
Christensen, D. E......N. Mich. TB San., Gaylord 49735
Christensen, Willis L.....617 North Court, Gaylord 49735
Clippert, C. G. (R)...308 Michigan Ave., Grayling 49738
Coulter, Keith D. (R)................8019 Garlot Drive, Annandale, Va. 22003
Crandell, Clare H. (R).............West Branch 48661
Dosch, Paul..........................Grayling 49738
Forney, Fred A. (L)
Godfroy, Bernard...................Roscommon 48653
Hayes, Louis F.............7330 Deep Run Lane #1523, Birmingham 48020
Henig, Benj. E........................Grayling 49738
Howarth, Thos. W......................Gladwin 48624
Jardine, Hugh M...................West Branch 48661
Kieler, George E.....................Roscommon 48653
Koltay, Marta Szego............Tolfree Memorial Hosp., West Branch 48661
Koltay, Oscar P................Tolfree Memorial Hosp., West Branch 48661
Libke, Robert S.......................Gaylord 49735
Oppy, Charles L....................Roscommon 48653
Potvin, Clifford D.....308 Michigan Ave., Grayling 49738
Rusak, R. D...........................Gladwin 48624
Schaiberger, Geo. L.................West Branch 48661
Stealy, Stanley A. (L).................Grayling 49738
Timreck, Harold A.....................Gladwin 48624
Tongco, Rustico C.......617 N. Court St., Gaylord 49735
Van Oosten, Howard E...117 Burgess, West Branch 48661
Wiegerink, L. T...................West Branch 48661

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R)......4622 Concord Ct., Midland 48640
Basel, Arthur R...........901 Crescent, Midland 48640
Benjamin, Mac B............307 Cass St., Sanford 48657
Bennett, Donald R......3902 Applewood, Midland 48640
Bernier, Jos. A...........218 E. Railway, Sanford 48657
Blackhurst, J. F......2715 Ashman Street, Midland 48640
Blackhurst, Robt. T........233 E. Larkin, Midland 48640
Bowsher, Robt. E.......4005 Orchard Dr., Midland 48640
Bridge, Robt. G............2715 Ashman, Midland 48640
Bulmer, Dan J..........2707 Ashman St., Midland 48640
Bush, Raymond C........808 W. Sugnet, Midland 48640
Buskirk, Maurice D.......110 W. Sugnet, Midland 48640
Cline, J. Daniel..........920 W. Sugnet, Midland 48640
Devlin, James A.............115 Jerome, Midland 48640
Ducommun, Dale J.........Dow Chemical Co. Box 469, Midland 48640
Ellis, Ruth.................2510 Ashman, Midland 48640
Esparza, Higinio S.
Fields, Dozier N., Jr.....515 W. Main St., Midland 48640
Gay, Harold H. (R)...Dow Chemical Co., Midland 48640
Goethe, Roy M.......222 N. Saginaw Rd., Midland 48640
Gordon, Harold L.....Dow Chemical Co., Midland 48640
Grant, Robert...........2931 Manor Dr., Midland 48640
Grewe, Norman C........501 E. Pine St., Midland 48640
Gunderson, Edw. P....2000 Dilloway Dr., Midland 48640
Haberstroh, Colleen.....3710 Applewood, Midland 48640
Harrigan, William E.......2706 Louanna, Midland 48640
Heffernan, D. D..........402 Dartmouth, Midland 48640
Himmelsbach, Wm. A........5411 Sturgeon Crk. Pkwy., Midland 48640
Holder, Benj. B............Dow Chem. Co. Med. Dept., Midland 48640
Holland, Frederick R.....1801 Rapanos, Midland 48640
Howe, Irvin M..........110 W. Sugnet, Midland 48640
Howell, Richard H.........2707 Ashman, Midland 48640
Ittner, Martin J.......217 N. Saginaw Rd., Midland 48640
Johns, David B............Dow Chemical Co. Box 469, Midland 48640
Kiyak, Yahya..............206 Graham, Midland 48640
Kramer, Chas. G...Box 469, Dow Chemical, Midland 48640
Kwast, Harold A...........2715 Ashman, Midland 48640
Linsenmann, Karl W.....2604 Manor Dr., Midland 48640
Marks, V. A..............2706 Louanna, Midland 48640
Maynard, Wm. A..........208 N. Fourth, Coleman 48618
Meisel, Edward H., Jr......Masonic Bldg., Midland 48640
Mesaros, Michael P...222 N. Saginaw Rd., Midland 48640
Moench, G. Fredk.........147 Center St., Sanford 48657
O'Hona, Bernard A.......110 W. Sugnet, Midland 48640
Pike, Melvin H..........224 E. Larkin, Midland 48640
Pollock, Robert.........2707 Ashman St., Midland 48640
Poznak, Leonard A.....4005 Orchard Dr., Midland 48640
Randolph, Stephen H. 201 E. Ellsworth St., Midland 48640
Redmon, William B..........115 Jerome, Midland 48640
Reif, James........222 N. Saginaw Rd., Midland 48640
Sanislow, Charles A.....2707 Ashman St., Midland 48640
Scharf, Forrest.........4005 Orchard Dr., Midland 48640
Scharnweber, H. C....Dow Chemical Co., Midland 48640
Schoff, Charles A..........2706 Louanna, Midland 48640
Shriner, John W......222 N. Saginaw Rd., Midland 48640
Smith, Donald S., Jr. (M)..2715 Ashman, Midland 48640
Smock, Sidney N.........2006 Norwood, Midland 48640
Towsley, Wilbur D.......515 W. Main St., Midland 48640
Ulmer, George............4005 Orchard, Midland 48640
Van Sickle, Robert L...............222 N. Saginaw Rd., Midland 48640
Westphal, Harry O.........910 Eastlawn, Midland 48640
Willison, Chas. H.......122 Townsend St., Midland 48640
Yobst, G. James...........2719 Ashman, Midland 48640

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D. (L)..2 W. Noble Ave., Monroe 48161
Barrett, C. D., Sr. (L) 2133 Hollywood Dr., Monroe 48161
Bartolo, Anthony H........757 N. Monroe, Monroe 48161
Black, Charles E.......721 N. Macomb St., Monroe 48161
Blakey, Leonard C. (L) 745 N. Monroe St., Monroe 48161
Bond, Wm. W............222 N. Monroe, Monroe 48161
Burroughs, J. J.........745 N. Monroe St., Monroe 48161
Cigany, Zoltan B........................Carleton 48117
Clark, Bruce........8308 Lewis Ave., Temperance 48182
Costa, Frank..........21941 Woodruff, Rockwood 48173
Diehl, George Z..........721 N. Macomb, Monroe 48161
Diehl, Joy O. S..........15463 S. Monroe, Monroe 48161
Douglas, Dale W............124 Cole Rd., Monroe 48161
Dranginis, E. J.........Memorial Hospital, Monroe 48161
Ewing, Robt. T. (L)....130 Maple Blvd., Monroe 48161
Flanders, John P.......753 N. Monroe St., Monroe 48161
Frary, Reginald A..........505 Strasburg, Monroe 48161
Freud, John W.......1262 N. Macomb St., Monroe 48161
Hensel, Hilda M............12 E. 4th St., Monroe 48161
Hnatczuk, Nikolas..8078 Summerfield, Lambertville 48144
Ivanichek, Francis....610 N. Macomb St., Monroe 48161
Johnson, A. Esther.....751 N. Monroe St., Monroe 48161
Kelso, S. Newton, Jr.........116 Cole Rd., Monroe 48161
King, John R.............12 East 4th St., Monroe 48161
Laboe, Edward W. (R)....424 Hollywood, Monroe 48161
Lammers, Gerald P.........................Ida 48140
Libres, Joseph........721 N. Macomb St., Monroe 48161
Liedel, Warren J...........136 Cole Rd., Monroe 48161
Long, Edgar C.......1310 N. Macomb St., Monroe 48161
Lusher, William T....8308 Lewis Ave., Temperance 48182
McGeoch, Reginald W. (L)........718 N. Macomb St., Monroe 48161
McMillin, John H. (L)....423 E. Elm St., Monroe 48161
Mehregan, Amir H.......12 E. Fourth St., Monroe 48161
Meier, Walter A............134 Cole Rd., Monroe 48161
Middleton, W. S......219 W. Front Street, Monroe 48161
Ozdaglar, Mehmet N......721 N. Macomb, Monroe 48161
Pena, Emilio.............424 Monroe St., Dundee 48131
Pinkus, Hermann K. B.......12 E. 4th St., Monroe 48161
Reisig, Albert H.........1 S. Monroe St., Monroe 48161
Sisman, Bernard............130 Cole Rd., Monroe 48161
Streicher, Robt. G......729 N. Monroe St., Monroe 48161
Tomlinson, Ledyard H.....8718 Main St., Newport 48166
Wagar, Spencer H......31 Washington St., Monroe 48161
Weeks, Vernon L.........749 N. Monroe, Monroe 48161
Wilkins, Rolland W.........118 Cole Rd., Monroe 48161
Williams, Robt. J. (L)..31 Washington St., Monroe 48161

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Aardema, Austin A.......1470 Peck St., Muskegon 49441
Allen, Richard T...768 W. Broadway, Muskegon Hts. 49444
Alt, William J......Medical Arts Center, Muskegon 49440
Amos, David A..307 Medical Arts Bldg., Muskegon 49440
Annessa, G. W.....Medical Arts Center, Muskegon 49440
Askam, Ralph F.....Medical Arts Center, Muskegon 49440
Atkinson, Annie L. (A)...........R. 1, Montague 49437
August, Ralph V.......................72 E. Broadway, Muskegon Heights 49444
Barnard, Helen S. (R)...........1382 E. Airport Rd., Muskegon 49441
Barnes, James W...102 Professional Bldg., Montague 49437
Barnett, James M. (M)...........2892 Baylis Dr. North, Ann Arbor 48104
Benedict, Arthur L., Jr.............22 W. Southern Ave., Muskegon 49441
Bloom, Robt. E.....Medical Arts Center, Muskegon 49440
Bolthouse, Robt. E...2101 Peck St., Muskegon Hts. 49444

Bond, Wm. H..........1282 Arthur St., Muskegon 49442
Boyd, DeVere R..........1735 Peck St., Muskegon 49441
Boyd, Jack L. (A).......1735 Peck St., Muskegon 49441
Bradshaw, Park S...Medical Arts Center, Muskegon 49440
Bultema, James H........1470 Peck St., Muskegon 49441
Busard, J. Max..........1200 Ransom, Muskegon 49442
Busard, Thos. R.....Medical Arts Center, Muskegon 49440
Carlson, Mr. James C. (A) 2060 Belmont, Muskegon 49441
Chapin, Wm. S. (A)..................2125 Maffett St., Muskegon Heights 49444
Chiasson, Antonio....4056 Nob Hill Dr., Muskegon 49441
Christophersen, J. W...............1276 Lake Shore Dr., Muskegon 49444
Clapp, Henry W...............202 Westgate Med. Twr., Muskegon 49441
Clifford, James D. (A)......452 Maple, Plymouth 48170
Closz, Harold F. (L)..1727 Jefferson St., Muskegon 49441
Cornell, Homer E...303 Medical Arts Ctr., Muskegon 49440
Crawford, John W., Jr.....1470 Peck St., Muskegon 49441
Cronick, Anne B.....435 Whitehall Rd., Muskegon 49445
Dart, Dorothy O. (A).............428 W. Franklin St., Salisbury, N.C. 28144
Das, Kshitish.........506 Liberty Life Bldg., Muskegon
Dasler, Adolph F.........1507 Peck St., Muskegon 49441
De Leeuw, Henry....4090 Highgate Rd., Muskegon 49441
DeYoung, Roland W...3800 Monteview, Muskegon 49441
Diskin, Frank.....1324 Marquette Ave., Muskegon 49442
Ellis, Nicholas J...1891 Lake Shore Dr., Muskegon 49444
Engstrom, Albert D......117 W. Colby, Whitehall 49461
Farmer, John C.....Medical Arts Center, Muskegon 49440
Fillingham, Enid (R)....1034 Giles Rd., Muskegon 49445
Fles, Robt. J.............1715 Peck St., Muskegon 49441
Folsom, John D..........1706 Peck St., Muskegon 49441
Frandsen, Philip H.......1470 Peck St., Muskegon 49441
Fry, Phillip E. (A)..............2774 Patricia, Apt. 10, North Muskegon 49445
Fugate, E. M...206 Westgate Med. Twr., Muskegon 49441
Gaikema, Everett W. (R)................605 First St., North Muskegon 49445
Gamble, Robert N...............1310 Wisconsin Ave., Grand Haven 49417
Garber, Frank W., Jr.........1732 Peck, Muskegon 49441
Garber, Frank W. (L).............235 Monroe Avenue, Muskegon 49441
Garrison, Robt. E., Jr.............210 Med. Arts Bldg., Muskegon 49440
Giese, Douglas H.............305 Westgate Med. Twr., Muskegon 49441
Gillard, James L.........1642 Peck St., Muskegon 49441
Goltz, Martha H. (L)................Montague 49437
Grasman, Erwin.........3068 Wittkop, Muskegon 49440
Griffith, Robt. M....................966 W. Broadway, Muskegon Hgts. 49441
Hack, Donald W....Medical Arts Center, Muskegon 49440
Hanley, Wm. J.......315 W. Clay Ave., Muskegon 49440
Harris, W. Richard........852 Winslow, Muskegon 49441
Harryman, James E.....1200 Ransom St., Muskegon 49442
Hartwell, Shattuck W.................Northshore Hosp., North Muskegon 49445
Harvey, John G. Klemm (R)...........Mercy Hospital, Muskegon
Heeres, Dale W.....1135 Hampden Rd., Muskegon 49441
Heneveld, John (R).............Brasstown, N.C. 28902
Heneveld, Robt. G........1470 Peck St., Muskegon 49441
Hennessy, Mary E. (A) 1200 Ransom St., Muskegon 49442
Herald, Osbie J..............208 Westgate Medl. Twr., Muskegon 49441
Holly, Leland E. (L)..889 N. Second St., Muskegon 49440
Holly, Leland E., II..889 N. Second St., Muskegon 49440
Holm, Leo H.....212 Medical Arts Ctr., Muskegon 49440
Hornbeck, Wm. J......1200 Ransom St., Muskegon 49442
Howard, W. Leonard..635 Franklin, N. Muskegon 49445
Huntley, Richard A............1704 W. Sherman Blvd., Muskegon 49441
Jesson, Robt. M........1200 Ransom St., Muskegon 49442
Johnston, E. H.......889 N. Second St., Muskegon 49440
Joistad, Arthur H., Jr...889 N. Second St., Muskegon 49440
Kane, Thos. J. (M)................2086 Leimert Blvd., Oakland, Ca. 94602
Kay, Cecelia S...........1533 Peck St., Muskegon 49441
Keilen, Marie (L).....Occidental Hotel, Muskegon 49443
Kelso, Charles T...15575 Oak Drive, Spring Lake 49456
Kerr, Howard J.........3054 Henry St., Muskegon 49444
Kislov, Richard...................1810 Ruddiman Ave., North Muskegon 49445
Kleaveland, Ingram J...1670 Peck Street, Muskegon 49441
Krenz, Marlin P...............Hackley Union Bk. Bldg., Muskegon 49443
Lange, Eugene W. (R)........680 Wauwatosa Rd., R 2, Cedarburg, Wi. 53012
Lauretti, Emil J.....Medical Arts Center, Muskegon 49440
Lauretti, L. A..........936 Second St., Muskegon 49440
Laurin, Vilda S. (L) Medical Arts Center, Muskegon 49440
Le Fevre, Geo. L., Jr. (R)...............726 Lake Dr., North Muskegon 49445
Le Fevre, Wm. M. (L) 315 W. Clay Ave., Muskegon 49440
Lemmen, Lloyd J.........1724 Peck St., Muskegon 49441
Leonard, Mr. A. T. (A).............435 Whitehall Rd., Muskegon 49445
Loder, Leonel L...289 W. Western Ave., Muskegon 49440
Lowry, Robt. A. (A)..300 Hopi Place, Boulder, Co. 80302
Maire, Lewis E..........1633 Peck St., Muskegon 49441
Mandeville, C. B. (L) 5311 N. Bristol, Tacoma, Wa. 98407
Maples, Douglas E.............2612 Riverview, Apt. 11, N. Muskegon 49445
Marrs, Jack Winton....Med. Arts Bldg., Muskegon 49440
McNair, John N.........936 Second St., Muskegon 49440
Medema, Paul E.......1017 Sanford St., Muskegon 49440
Meengs, Marvin B........1725 Peck St., Muskegon 49441
Miller, Phillip L..........1755 Peck St., Muskegon 49441
Mulder, Lambertus..Medical Arts Center, Muskegon 49440
Oden, C. L. A. (L)..Medical Arts Center, Muskegon 49440
Oslund, Richard R.....889 N. Second St., Muskegon 49440
Packer, Robert C........4065 Stamford, Muskegon 49441
Parsons, Frank W..............206 Westgate Med. Twr., Muskegon 49441
Paterson, Lester C.........1643 Peck St., Muskegon 49441
Peterson, Wm. F......1094 Jefferson St., Muskegon 49440
Pettinga, Frank L.........1470 Peck St., Muskegon 49441
Risk, Robt. D..........1160 Ransom St., Muskegon 49442
Sanden, Howard V........1643 Peck St., Muskegon 49441
Scholle, Norbert W.............204 Westgate Med. Twr., Muskegon 49441
Shebesta, Emil M...Medical Arts Center, Muskegon 49440
Smith, Robert E....Medical Arts Center, Muskegon 49440
Steffee, William P. (A)................442 Valhalla Ct., Rochester, Minn. 55901
Stone, Thomas E...1900 Crestwood Dr., Muskegon 49441
Stratton, Donald P.......889 Second St., Muskegon 49440
Stubbart, F. James 2416 Peck St., Muskegon Heights 49444
Stuk, Ronald L...Med. Arts Ctr., #103, Muskegon 49440
Swanson, Raymond E.............1315 Ruddiman Ave., North Muskegon 49445
Swedenburg, Robt. D...1470 Peck Street, Muskegon 49441
Swenson, Leland L.......1706 Peck St., Muskegon 49441
Tellman, H. Clay.........315 W. Clay, Muskegon 49440
Torrey, R. K.....Westgate Medical Bldg., Muskegon 49441
Toy, Chas. M...........1067 Pine St., Muskegon 49442
Tyler, Wm. H...........1435 Peck St., Muskegon 49441
Vandervelde, C. A........1470 Peck St., Muskegon 49441
Vangelder, Wm. C...Medical Arts Center, Muskegon 49440
Voikos, Geo. A..............1470 Peck, Muskegon 49441
Wagenaar, Edward H...3054 Henry St., Muskegon 49444
Welch, Norman L.........Mercy Hosp., Muskegon 49443
White, Warren G., Jr...........307 Westgate Med. Twr., Muskegon 49441
Wiersma, Silas C. (A).............University Hospital, Ann Arbor 48104
Wildgen, Bernard C. Medical Arts Center, Muskegon 49440
Wilke, Carl A. (R)....116B Warren AFB, c/o Maj. J. E. LaRue, Cheyenne, Wyo. 82003
Williams, Dale L.........1692 Peck St., Muskegon 49441
Williams, Edward V.....................2501 Baker St., Muskegon Heights 49444
Wilson, B. David (A)......15428 Archdale, Detroit 48227
Wolters, Burton J...103 Medical Arts Ctr., Muskegon 49440
Young, Malcolm C......1700 Clinton St., Muskegon 49442

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Decker, J. C................52 Maple S.E., Grant 49327
DeKryger, Maynard......220 W. Pine St., Fremont 49412
Deur, Theodore R...........52 Maple S.E., Grant 49327
De Young, Jess..........111 W. Dayton, Fremont 49412
Emerick, Robt. W...............Box 147, Fremont 49412
Geerlings, Lambert J. (L)..........194 N. Hillcrest Dr., Fremont 49412
Klein, J. Paul.............P.O. Box 111, Fremont 49412
Masters, Brooker L.......111 W. Dayton, Fremont 49412
Painter, Robert..............52 Maple S.E., Grant 49327
Paxton, Robt. E.............220 W. Pine, Fremont 49412
Pedelty, Norman...........38 State Rd., Newaygo 49337
Vanden Berg, Tunis........220 W. Pine, Fremont 49412

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F..........Lockwood Hosp., Petoskey 49770
Alm, Bernhard T.......418 Petoskey St., Petoskey 49770
Bingley, Leo J., Jr.......1018 Lindell St., Petoskey 49770
Blum, Benj. B.......1208 E. Mitchell St., Petoskey 49770
Burns, Dean C.................Route 1, Petoskey 49770
Chiu, Robert..............Burns Clinic, Petoskey 49770
Christie, Joseph W.............Beaver Island Med. Ctr., St. James 49782
Connaughton, P. J..........Burns Clinic, Petoskey 49770
Conti, Jos. B.........924 E. Mitchell St., Petoskey 49770
Conway, Wm. S............Burns Clinic, Petoskey 49770
Dawson, William A.........Burns Clinic, Petoskey 49770
Drake, Gerald............511 Waukazoo, Petoskey 49770
Elliott, Dean C............Burns Clinic, Petoskey 49770
Foster, Bradford S.........226 Park Ave., Petoskey 49770
Frye, Sanders A............Burns Clinic, Petoskey 49770
Grate, Lawrence E...3950 Rosehill Ave., c/o Miss Susan Grate, Cincinnati, Ohio 45229
Hegener, Aloysius J.....1020 Howard St., Petoskey 49770
Homsi, Rateb.........430 S. Main St., Cheboygan 49721
Kiley, James A..............310 9th St., Manistee 49660
Kirk, Thomas R. (A) 2222 Fuller Road, Ann Arbor 48105
Knecht, Richard A.........226 Park Ave., Petoskey 49770
Kutcipal, R. A...............211 Sunset, Petoskey 49770
Larson, Walter E........456 S. Huron, Cheboygan 49721
Lentini, Nicholas.....................Cheboygan 49721
Lignell, John H.......R. 3, Division St., Charlevoix 49720
Martin, Robt. G...........707 Bridge, Charlevoix 49720
Mateskon, Victor S.........Sunset Blvd., Petoskey 49770
Mayne, Frederick C. (L) P. O. Box 387, Cheboygan 49721
McCullough, W. L........115 Clinton St., Petoskey 49770
McEnroe, John E....1005 E. Mitchell St., Petoskey 49770
McKnight, Robt. D........Lincoln Place, Petoskey 49770
Mertz, Joanne E.............Resort Pike, Petoskey 49770
O'Keefe, N. Thomas.........516 Bay St., Petoskey 49770
Peckham, Richard C...............3480 Hillcrest Circle, Carlsbad, Ca. 92008
Postle, Jack R.........Arlington Heights, Petoskey 49770
Rauch, Carl T.......420 Riverside Dr., Cheboygan 49721
Reus, Leonard W.........226 Park Ave., Petoskey 49770
Rodger, John R.........................Bellaire 49615
Ryan, Mary Harmon..........1705 Chief Okemos Circle, Okemos 48864
Saltonstall, G. B. (L)...112 Clinton St., Charlevoix 49720
Savory, John H......................East Jordan 49727
Shanahan, Robt. E.....1125 Valley View, Petoskey 49770
Sheets, John A.............929 Michigan, Petoskey 49770
Simard, J. E. Henri....Pennsylvania Plaza, Petoskey 49770
Smith, James R...........901 Spruce St., Petoskey 49770
Snide, Rollin F.......125 N. Main St., Cheboygan 49721
Stringham, James R. (L) 225 Backus St., Cheboygan 49721
Tanton, John H............Burns Clinic, Petoskey 49770
Taylor, Robt. M...........Lincoln Place, Petoskey 49770
Tsaloff, Victor.............Burns Clinic, Petoskey 49770
Uhlich, Gustav A.........E. Mitchell Rd., Petoskey 49770
Van Dellen, Jerrian........Water St., East Jordan 49727
Vanden Brink, R. D.........Burns Clinic, Petoskey 49770
Weber, Richard............Burns Clinic, Petoskey 49770
Webster, Jean H..........200 Sunset St., Petoskey 49770
Weburg, Kathryn D.............Route 3, Petoskey 49770
Zipf, Charles (A)..1326 S. Park Blvd., Freeport, Ill. 61032

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C.....1405 Pontiac St. Bk., Pontiac 48058
Abbrecht, Martin M.....800 S. Adams, Birmingham 48011
Adair, Robin..........800 S. Adams, Birmingham 48011
Adelson, Seymour S...............20905 Greenfield Rd., Southfield 48075
Albert, Donald G...3535 W. 13 Mile Rd., Royal Oak 48072
Albrecht, Robt. W.................2111 Cass Lake Rd., Keego Harbor 48033
Alexander, Joseph B. (A)..........900 Woodward Ave., Pontiac 48053
Alkar, Yasar M.................159 Pierce St., No. 202, Birmingham 48011
Alshabkhoun, Adnan.33100 12 Mile Rd., Farmington 48024
Andrakovich, F.......5554 Lahser Rd., Birmingham 48010
Angammal, N. (A)....Pontiac State Hosp., Pontiac 48053
Aragones, Jaime V..134 W. University Dr., Rochester 48063
Arena, Joseph A., Jr...............31815 Southfield Rd., Birmingham 48009
Arnkoff, Harry..............150 E. Long Lk. Rd., #106, Bloomfield Hills 48013
Arons, Roy E.......7133 Lindenmere, Birmingham 48010
Ashare, Raymond...........35 S. Johnson, Pontiac 48053
Atash, Manou C..........4173 Brandywine, Troy 48084
Aulie, Hal G......3535 W. 13 Mile Rd., Royal Oak 48072
Avaregan, Mohsen............6707 Heather Heath Ln., Birmingham 48010
Avci, Mustafa..6846 Cooley Lake Rd., Union Lake 48085
Awes, Lorraine E.......500 W. Huron St., Pontiac 48053
Ayrom, Kambiz........19827 Monte Vista, Detroit 48221
Baier, Kurt....3816 Crestlake Dr., Bloomfield Hills 48013
Baker, Frederick A. (L)..........1936 W. Anklam Rd., Tucson, Az. 85705
Balian, John V...........134 W. University Drive # 201, Rochester 48063
Bannow, Robt. J.....880 Woodward Ave., Pontiac 48053
Barker, Chas. P.....214 Wabeek Bldg., Birmingham 48011
Barker, Howard B. (L)................490 Martell Dr., Bloomfield Hills 48013
Barlow, Peter P...31815 Southfield Rd., Birmingham 48009
Barnes, Bradley T........312 Maywood, Rochester 48063
Barnes, Donald J. (L)..20 Norwich, Pleasant Ridge 48069
Barr, Norman L................965 Orchard Ridge Rd., Bloomfield Hills 48013
Barrett, John L.............3535 W. 13 Mile Rd., #608, Royal Oak 48072
Barron, Robert A...............4256 Orchard Lake Rd., Orchard Lake 48033
Barsch, Henry J..............21634 E. Valley Wds. Dr., Birmingham 48010
Bauer, Bruce D.....3229 Woodward Ave., Berkley 48072
Bauer, Edward G........101½ N. Saginaw, Pontiac 48058
Bauer, Ernest W., Sr. (L)........3229 Woodward Ave., Berkley 48072
Bauer, E. William...3229 Woodward Ave., Berkley 48072
Bauer, Franz.........909 Woodward Ave., Pontiac 48053
Baylis, Shelby M...........35 S. Johnson, Pontiac 48053
Beattie, Willard G. (R)..............2500 Sample Rd., Pompano Beach, Fl. 33064
Beauregard, Wm. L...............3535 W. 13 Mile Rd., Royal Oak 48072
Beck, Otto O. (L)..308 Wabeek Bldg., Birmingham 48011
Becker, Paul M....1890 Southfield Rd., Birmingham 48009
Belknap, Warren F. 1809 S. Main St., Pleasant Ridge 48069

Benjamin, Durand, Jr. (A)........Pontiac General Hosp., Pontiac 48053
Benoit, Merrill P...Pontiac Mtr. Div., GMC, Pontiac 48053
Berg, Richard M......880 Woodward Ave., Pontiac 48053
Berger, Chas. J..........1500 Linwood, Royal Oak 48067
Berman, Bernard D. 1200 N. Telegraph Rd., Pontiac 48053
Berman, Gilbert M......24601 Coolidge, Oak Park 48237
Beuker, John T.............15901 W. 9 Mile Rd., #206, Southfield 48075
Beyer, Hans A........5675 Kolly Rd., Birmingham 48010
Birkelo, Carl H...4680 Dixie Hwy., Drayton Plains 48020
Blakency, James R.........17 Utica Road, Pontiac 48053
Blanco, Maximino J. (A)..........Pontiac State Hosp., Pontiac 48053
Bloomberg, Sanford..............23023 Orchard Lk. Rd., Farmington 48024
Blue, Jane............19125 Hillcrest, Birmingham 48009
Boesky, Malcolm D..............26789 Woodward Ave., Huntington Wds. 48070
Boileau, Thornton I...............2075 E. 14 Mile Rd., Birmingham 48008
Bolton, Alan E. (A)..............3601 W. 13 Mile Rd., Royal Oak 48072
Bookmyer, Robt. M...............31815 Southfield Rd., Birmingham 48009
Boss, Peter E. (A)..............3601 W. 13 Mile Rd., Royal Oak 48072
Boucher, Roman E.............4200 N. Woodward Ave., Royal Oak 48072
Boutros, Nabil R..134 W. University Dr., Rochester 48063
Bowers, Chas. L.....909 Woodward Ave., Pontiac 48053
Bradley, Geo. T...3535 W. 13 Mile Rd., Royal Oak 48072
Brady, Neal C.....3535 W. 13 Mile Rd., Royal Oak 48072
Brantley, Robt. E. (A)..............31260 E. Rutland, Birmingham 48009
Brogan, Edward (A).900 Woodward Ave., Pontiac 48053
Bronson, Wm. W......................28119 John R St., Madison Heights 48071
Brown, Arnold L...........35 S. Johnson, Pontiac 48053
Bryan, Henry G.........22100 Coolidge, Oak Park 48237
Bryan, John B.....4045 W. 13 Mile Rd., Royal Oak 48072
Bryant, F. W.....3535 W. 13 Mile Rd., Royal Oak 48072
Budd, Alexander S. Z...............3511 Lakecrest Dr., Bloomfield Hills 48013
Buehrig, Robert C...........5790 M 15, Clarkston 48016
Bullard, R. W., Jr...........5790 M 15, Clarkston 48016
Bunto, William G.......5965 Orion Rd., Rochester 48063
Burger, John H...31815 Southfield Rd., Birmingham 48009
Burgess, Bruno.......29250 Longview St., Warren 48093
Burke, Chauncey G......35 W. Huron St., Pontiac 48058
Burtka, Joseph F..16505 John R St., Madison Hgts. 48071
Byberg, Robt. A...3535 W. 13 Mile Rd., Royal Oak 48072
Cabrera, G. P.....3535 W. 13 Mile Rd., Royal Oak 48072
Calhoun, Ethel T. (L)..............707 Lakeview Ave., Birmingham 48009
Calver, David R. (A)............Pontiac Gen. Hospital, Pontiac 48053
Campbell, K. N..................1465 Cedar Bend Dr., Bloomfield Hills 48013
Campbell, Malcolm D. (R).........435 Ridgewood Rd., Key Biscayne, Fl. 33149
Carioni, Juan C. (A)............Wm. Beaumont Hosp., Royal Oak 48072
Carlisle, Jos. D....3535 W. 13 Mile Rd., Royal Oak 48072
Carlson, Barbara F. (A)........St. Joseph Mercy Hosp., Pontiac 48053
Carpenter, G. B., Jr. 622 N. Woodward, Birmingham 48011
Carrow, Joyce M. (A)............1469 Highmoor Way, Bloomfield Hills 48013
Cashman, Edward F.....18715 Bretton Dr., Detroit 48223
Castedo, Nicanor F...............4189 Sunningdale Dr., Bloomfield Hills 48013
Cecchini, Richardo E. (A)........3601 W. 13 Mile Rd., Royal Oak 48072
Cefai, Anthony F...........35 S. Johnson, Pontiac 48053
Cerkez, C. T.........134 W. University, Rochester 48063
Chandler, Douglas 1890 Southfield Rd., Birmingham 48009
Chandler, Jos. H.............309 Northland Med., Bldg., Southfield 48075
Cheng, James T. (R)...............30 Molly Stark Dr., Morristown, N.J. 07960
Cherup, Nicholas....Pontiac General Hosp., Pontiac 48053
Childers, Merle A..134 W. University Dr., Rochester 48063
Chisa, Neldagae................26711 Woodward Ave., Huntington Wds. 48070
Chow, Cynthia................1969 Hunters Ridge Dr., Bloomfield Hills 48013
Chung, Tai (A)......Pontiac State Hosp., Pontiac 48053
Clair, Alvin H. (M)............1195 Veltre Circle S.W., Atlanta, Ga. 30311
Clarke, Harriet A.............488 S. Fox Hills Drive #3, Bloomfield Hills 48013
Cline, Alan L......4299 Roseberry, Drayton Plains 48020
Cobb, Thos. H.......880 Woodward Ave., Pontiac 48053
Cohen, Carl J.....909 Woodward, No. 110, Pontiac 48053
Cohen, Daniel H...20905 Greenfield Rd., Southfield 48075
Cohen, Jack J........17226 Adrian Rd., Southfield 48075
Cohen, Lewis..26602 Dundee Rd., Huntington Wds. 48070
Cohen, Melvin F. 28590 Rivercrest Drive, Southfield 48075
Colakoglu, Celal..........2669 Coolidge, Berkley 48072
Collins, Edward F........35 W. Huron St., Pontiac 48058
Condon, Frank J...27725 Greenfield Rd., Southfield 48075
Conrad, Cecil D...............3027 N. Woodward Ave., Royal Oak 48072
Cooksey, Norton J. 3535 W. 13 Mile Rd., Royal Oak 48072
Cooley, Roy V...........318 S. Blvd. West, Pontiac 48053
Cooper, Edmond L.............4200 N. Woodward Ave., Royal Oak 48072
Cooper, Robt. S...............3027 N. Woodward Ave., Royal Oak 48072
Corrigan, K. E., Ph.D. (A)............300 Warren Court, Birmingham 48009
Coskey, Ralph J.........22100 Coolidge, Oak Park 48237
Coucke, Henry O. (R)............30785 Woodgate Dr., Southfield 48075
Counts, Robert W................155 Reddingwood Dr., Rochester 48063
Crum, Roger E.............35 S. Johnson, Pontiac 48053
Cutler, Robert M.....909 Woodward Ave., Pontiac 48053
Cutler, Wm. M.....800 S. Adams Rd., Birmingham 48011
Dahlgren, Carl W. (L).............3023 Orchard Lake, Keego Harbor 48033
Darling, C. G., Jr.....880 Woodward Ave., Pontiac 48053
Darnley, James D...............26711 Woodward Ave., Huntington Woods 48070
Dawson, Donald N....Pontiac State Hosp., Pontiac 48053
Dayton, Richard C...............427 W. University Dr., Rochester 48063
Deighton, Murray N...........23023 Orchard Lake Rd., Farmington 48024
Delaney, Malcolm J...........23023 Orchard Lake Rd., Farmington 48024
De Lawter, Hilbert H.............3535 W. 13 Mile Rd., Royal Oak 48072
Delevie, Jacob B.........640 Riker Bldg., Pontiac 48058
Derr, J. William..3535 W. 13 Mile Rd., Royal Oak 48072
Deutsch, Wm. L...600 W. 11 Mile Rd., Royal Oak 48067
De Vito, H. Louis.......3115 Angelus Dr., Pontiac 48055
Dinger, David H...2561 Elizabeth Lk. Rd., Pontiac 48054
Dito, William R.....Pontiac General Hosp., Pontiac 48053
Dobski, Edwin J.....909 Woodward Ave., Pontiac 48053
Doerr, Louis E., Jr...1413 S. Washington, Royal Oak 48067
Donnelly, Wm. J...909 Woodward Avenue, Pontiac 48053
Dooley, William D......35 S. Johnson St., Pontiac 48053
Dorostkar, Massoud....4821 Sedgemoor, Royal Oak 48073
Dorsey, John M., Jr...............31815 Southfield Rd., Birmingham 48009
Drew, Dale R........909 Woodward Ave., Pontiac 48053
Drogowski, Edward J..134 W. University, Rochester 48063
Duhamel, Peter A.....1055 Stellma Lane, Rochester 48063
Dunlap, Gregg L...............2870 Orchard Lake Rd., Keego Harbor 48033
Dunn, Lewis E......3924 Twelve Mile Rd., Berkley 48072
Durak, Gerald G...7105 Sherwood Dr., Birmingham 48010
Durocher, Normand E.......35 S. Johnson, Pontiac 48053
Dustin, Robt. W.....1314 W. Lincoln, Birmingham 48009
Elder, Edward E., Jr........1116 Voorheis, Pontiac 48054
Elliott, Robt. N...3535 W. 13 Mile Rd., Royal Oak 48072
Elton, Richard F..........15901 W. 9 Mile Rd., #620, Southfield 48075
Endress, Z. F., Jr...........35 S. Johnson, Pontiac 48053
Engel, John B. (R).....15463 Asbury Park, Detroit 48227

Ensroth, Jack F....1100 N. Woodward, Birmingham 48011
Ergin, Nevit O......................860 Lone Pine Rd., Bloomfield Hills 48013
Esslinger, John O...............622 N. Woodward Ave., Birmingham 48011
Esslinger, Valentine..........3535 W. Thirteen Mi. Rd., Royal Oak 48072
Estanislao, A. P.............5790 M 15, Clarkston 48016
Evseeff, Geo. S.....3535 W. 13 Mile Rd., Royal Oak 48072
Farah, Jalil........3525 Brookside, Bloomfield Hills 48013
Fargher, Robert A...660 South Boulevard E., Pontiac 48053
Feldstein, Jerome E. (A).......3601 West 13 Mile Rd., Royal Oak 48072
Fidler, Wm. F.....1200 N. Telegraph Rd., Pontiac 48053
Fink, L. Jerome........500 W. Huron St., Pontiac 48053
Finkell, Lawrence J...15231 W. 7 Mile Rd., Detroit 48235
Finkelstein, Lionel......577 Arlington, Birmingham 48009
Fishman, Gordon R. A...25717 Coolidge, Oak Park 48237
Flaharty, Wm. J. 25000 W. Ten Mile Rd., Southfield 48075
Flanagan, Paul....540 Weybridge, Bloomfield Hills 48013
Fleurquin, A. G...................4415 Park Lane Ct., Bloomfield Hills 48013
Flick, John R.......120 W. Second St., Royal Oak 48067
Fox, Ralph M.......800 S. Adams Rd., Birmingham 48011
Franco, Napoleon.....Pontiac State Hosp., Pontiac 48053
Freedman, Arthur M...........20100 West 12 Mile Rd., Southfield 48075
Frey, James L............Northland Med. Bldg., #704, Southfield 48075
Furlong, Harold A. (L)..35 S. Johnson Ave., Pontiac 48053
Fushman, John A...............4200 N. Woodward Ave., Royal Oak 48072
Gaba, Howard B...8245 Hendrie, Huntington Woods 48070
Gaber, Ben......10831 W. Ten Mile Rd., Oak Park 48237
Gadbaw, Jos. J.....33925 Oakland St., Farmington 48024
Gaensbauer, F.............1965 N. Hammond Lake Rd., Pontiac 48053
Gagliardi, R. A.......880 Woodward Ave., Pontiac 48053
Galens, Gilbert J. 31815 Southfield Rd., Birmingham 48009
Galpin, Richard R...525 Southfield Rd., Birmingham 48009
Garber, Max J.................23023 Orchard Lake Rd., Farmington 48024
Garland, Donald M..........Pont. Motor, Glenwood Av., Pontiac 48053
Gates, Edward M.....Harbin Clinic, Rome, Georgia 30161
Gates, Joann M.......65 S. Telegraph Rd., Pontiac 48053
Gatley, Leslie W..........35 W. Huron St., Pontiac 48058
Gause, Richard C. 31815 Southfield Rd., Birmingham 48009
Gayles, Carlos B. (A)..........473 Kuhn, Pontiac 48057
Gehringer, Norman F...........2335 S. Commerce Rd., Walled Lake 48088
Geist, Edgar J., Jr.....1500 Walton Blvd., Rochester 48063
Gell, James W.........35 S. Johnson Ave., Pontiac 48053
Gelstein, Lazaro......909 Woodward Ave., Pontiac 48053
Gelzayd, Eugene A..20905 Greenfield Rd., Southfield 48075
Gerber, George R. 310 W. University Dr., Rochester 48063
Gerls, Frank B. (L)...4425 Motorway Dr., Pontiac 48054
Gibson, Wellington C....206 E. Commerce, Milford 48042
Gill, Matthew J..........1030 Riker Bldg., Pontiac 48058
Glen, Harold..........26684 Grand River, Detroit 48240
Goerner, Dorothy M. (A)..338 Pilgrim, Birmingham 48009
Goldberg, Howard S..............24777 Greenfield Rd., Southfield 48075
Goldstein, Herbert..22100 Coolidge Hwy., Oak Park 48237
Good, Wayne T...3306 Auburn Rd., Auburn Heights 48057
Goode, Norman J., Jr.....2000 Second Ave., Detroit 48226
Gordon, Clayton H..............1099 N. Cranbrook Rd., Birmingham 48009
Gordon, Seymour..3535 W. 13 Mile Rd., Royal Oak 48072
Gradolph, Paul L...23338 Woodward Ave., Ferndale 48220
Gray, Murray H.........22100 Coolidge, Oak Park 48237
Grayson, Joseph R..........156 Palmer St., Pontiac 48053
Green, J. Donald....217 Briggs Bldg., Birmingham 48011
Green, Ralph S.........24100 Stratford, Oak Park 48237
Green, Willard M...........35 S. Johnson, Pontiac 48053
Grekin, John N...........15901 W. 9 Mile Rd., #620, Southfield 48075
Grekin, Thos. D...3535 W. 13 Mile Rd., Royal Oak 48072
Gurol, Feridun....32316 Grand River, Farmington 48024
Gustafson, David C...............3535 W. 13 Mile Rd., Royal Oak 48072
Gustafson, Everette..........35 S. Johnson, Pontiac 48053
Gutterman, Meyer A..............25085 Coolidge Hwy., Oak Park 48237
Haanes, Merle A......909 Woodward Ave., Pontiac 48053
Hague, Gilbert W...................739 Westview Rd., Bloomfield Hills 48013
Halsted, Lee H................23023 Orchard Lake Rd., Farmington 48024
Hambalgo, George J.
Hamburger, Joel I...20905 Greenfield Rd., Southfield 48075
Hamilton, Quentin P...20905 Greenfield, Southfield 48075
Han, Maolin....3358 Auburn Rd., Auburn Heights 48057
Harmon, Lewis G. 1775 E. 14 Mile Rd., Birmingham 48008
Harrold, John A.........534 Franklin Rd., Pontiac 48053
Harvey, Campbell (L).........San Miguel DeAllende, APTADO, Postal 127, Guanajuato, Mexico
Hasegawa, Carl M......1800 Tuxedo Ave., Detroit 48206
Hassberger, John B.............620 N. Woodward Ave., Birmingham 48011
Hathaway, Wm. S...........433½ Main, Rochester 48063
Hayden, H. S., Ph.D. (A)............300 Warren Court, Birmingham 48009
Hecht, Manes S.....................26711 Woodward, Huntington Woods 48070
Heitsch, Joseph F. (A)..3860 Lonedale Rd., Pontiac 48057
Henderson, H. R...33750 Freedom Rd., Farmington 48024
Henderson, James E...909 Woodward Ave., Pontiac 48053
Henderson, Worth W...............1307 S. Washington, Royal Oak 48067
Hendren, Owen S.............880 Woodward Ave., #19, Pontiac 48053
Hendricks, Frank R...............21701 W. 11 Mile Rd., Southfield 48075
Henry, Colonel R. (L)............125 W. Nine Mile Rd., Ferndale 48220
Hensley, Chas. B.....248 S. Broadway, Lake Orion 48035
Herman, Edward L........909 Woodward, Pontiac 48053
Hermes, Charles R.................4680 Dixie Highway, Drayton Plains 48020
Hess, Richard L. (A)............Pontiac Gen. Hospital, Pontiac 48053
Heyboer, Donald J...St. Joseph Mercy Hosp., Pontiac 48053
Hill, William E..........534 Franklin Rd., Pontiac 48053
Hoekman, Aben (R)..........1740 Hamilton Dr., Rte. 3, Pontiac 48053
Hoffman, Lawrence D......20150 Audrey, Detroit 48235
Holmes, Keith M.....880 Woodward Ave., Pontiac 48053
Hopkins, Melvin, Jr.....900 Baldwin Ave., Pontiac 48055
Hopkins, Wm. J..............17000 W. Eight Mile Rd., Southfield 48075
Howard, Marjorie E. (A).........Pontiac General Hosp., Pontiac 48053
Howell, Lynn E......909 Woodward Ave., Pontiac 48053
Hrushka, Myroslaw....Pontiac State Hosp., Pontiac 48053
Hsu, John J.............35 W. Huron St., Pontiac 48058
Hubert, John R.......880 Woodward Ave., Pontiac 48053
Ignatius, Aram A...1915 E. Nine Mile Rd., Ferndale 48220
Ingold, John A.......3535 W. Thirteen Mile Rd., # 608, Royal Oak 48072
Isaac, Herbert L...909 Woodward Ave., 115, Pontiac 48053
Isgut, Robert D.........28477 Hoover Rd., Warren 48093
Izenstark, J. L.................Cedars Sinai Med. Ctr., 4833 Fountain Ave., Los Angeles, Ca. 90029
Jackson, Philip J..........23480 Church, Oak Park 48237
Jacobi, Rodman C.......91 S. Washington, Oxford 48051
Jacobson, Herbert S.............20905 Greenfield, #400, Southfield 48075
Jagnow, Nanette...525 Southfield Rd., Birmingham 48009
James, Robt. E., Jr...2561 Elizabeth Lk. Rd., Pontiac 48054
James, Thomas P.....1387 Chesterfield, Birmingham 48009
Jenkins, Henry L............161 State St., Pontiac 48053
Jennings, John A...21707 W. 11 Mile Rd., Southfield 48075
Johnson, Clare G...909 S. Woodward Ave., Pontiac 48053
Johnson, J. Frederic...............23760 N. Woodward, Pleasant Ridge 48069
Johnson, James W.....2581 McClintock Rd., Pontiac 48053
Johnson, Robert H...............310 W. University Dr., Rochester 48063

Jones, Cyril D..............100 W. Hickory Grove Rd., Bloomfield Hills 48013
Joseph, Antoine L...4045 W. 13 Mile Rd., Royal Oak 48072
Joyce, John A.......413 Woodward Ave., Rochester 48063
Jury, Donald B. 1126 S. Woodward Ave., Royal Oak 48067
Kadian, George....20905 Greenfield Rd., Southfield 48075
Kamm, Robert L.......240 Daines St., Birmingham 48009
Karakuc, Raymond J.............Wm. Beaumont Hosp., Royal Oak 48072
Katz, Allan M. (A)....461 W. Huron St., Pontiac 48053
Katz, Sidney F..........17350 Dorset, Southfield 48075
Kaufman, Jack M...............26711 Woodward Ave., Huntington Woods 48070
Kay, Sherman A.....1026 S. Washington, Royal Oak 48067
Kaylor, Marietta J. (A)........2435 Elizabeth Lake Rd., Pontiac 48053
Kazdan, Louis L. 13801 W. Nine Mile Rd., Oak Park 48237
Keeffe, Eugene J..............468 W. Williamsbury Rd., Birmingham 48010
Kemp, Felix J........880 Woodward Ave., Pontiac 48053
Kendrick, H. F., Jr.........35 S. Johnson, Pontiac 48053
Kerr, Edwin C.......32749 Franklin Rd., Franklin 48025
Ketchum, Jesse....120 W. 11 Mile Rd., Royal Oak 48068
Kettler, Hans J.....25160 Edgemont Rd., Southfield 48075
Khaneja, Satish C...140 Elizabeth Lake Rd., Pontiac 48053
Khodadadeh, B.................4252 Orchard Lake Rd., Orchard Lake 48033
Kilar, Theodore W................31815 Southfield Rd., Birmingham 48009
Kinsley, George......909 Woodward Ave., Pontiac 48053
Klass, Arthur......1026 S. Washington, Royal Oak 48067
Klegman, Jerome H...........17000 W. Eight Mile Rd., Southfield 48075
Klein, Marvin E.............18400 W. Twelve Mile Rd., Southfield 48075
Klewicki, H. A........22720 Woodward, Ferndale 48220
Knights, Edwin M., Jr...16001 9 Mile Rd., Southfield 48075
Knox, Richard S. 422 Washington Sq. Pl., Royal Oak 48067
Koehler, Wm. H...3535 W. 13 Mile Rd., Royal Oak 48072
Koerner, Karl F...........1820 Crooks Rd., Troy 48084
Koltonow, Lawrence..........304 Northland Med. Bldg., Southfield 48075
Kornmesser, James G...........23023 Orchard Lake Rd., Farmington 48024
Korotney, Frank S. (A)...63 Charles Lane, Pontiac 48053
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Kozonis, Michael C....880 Woodward Ave., Pontiac 48053
Kozora, Elmer J...17650 W. 12 Mile Rd., Southfield 48075
Krane, Mark..2335 S. Commerce Rd., Walled Lake 48088
Kreindler, Alfred M.....200 Elm St., Birmingham 48008
Kresge, Bruce A.....1500 Walton Blvd., Rochester 48063
Krieger, Norman N.........402 Union St., Milford 48042
Krohn, Don R. 23023 Orchard Lake Rd., Farmington 48024
Kuhel, Eli H..........25415 Southfield, Southfield 48075
Kuhn, Anne K....4203 W. 13 Mile Rd., Royal Oak 48072
Kuhn, Robt. E.....4203 W. 13 Mile Rd., Royal Oak 48072
Kumar, G. Krishna (A)..........3601 W. 13 Mile Rd., Royal Oak 48072
Kurnetz, Ruben..10831 W. Ten Mile Rd., Oak Park 48237
La Ban, Myron M.........31815 Southfield Road # 32, Birmingham 48009
Labes, James....15101 W. McNichols Rd., Detroit 48235
Ladd, James E.......31815 Southfield, Birmingham 48009
Lahti, Paul T.....3600 W. 13 Mile Rd., Royal Oak 48072
Lambert, Alvin G. 3535 W. 13 Mile, 505, Royal Oak 48072
Lanard, Francis W...31504 Sunset Dr., Birmingham 48009
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Landry, Roy A.........5770 S. Main St., Clarkston 48016
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Laux, Philip J., Jr...3027 N. Woodward, Royal Oak 48072
Lawson, James M.....2605 W. Grand Blvd., Detroit 48208
Laxa, Antonio A..........14 Edgelake, Union Lake 48085
Layman, Douglas C...............3535 W. 13 Mile Rd., Royal Oak 48072
Leach, Chas. A., Jr. 525 Southfield Rd., Birmingham 48009
Leahy, Etta Link (R)......1616 Wiltshire, Berkley 48072
Leichtman, R. R.............5770 M 15, Clarkston 48016
Lessien, Bruce T. 4045 W. Thirteen Mile, Royal Oak 48072
Levin, Murray B...7046 Cathedral Dr., Birmingham 48010
Levine, Bernard.................25835 Parkwood Dr., Huntington Woods 48070
Levine, Robert S. (A) 900 Woodward Ave., Pontiac 48053
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Lichtwardt, Harry E..............3535 W. 13 Mile Rd., Royal Oak 48072
Lichtwardt, John R...............3535 W. 13 Mile Rd., Royal Oak 48072
Lievois, Edward G................289 Westbourne Dr., Birmingham 48010
Lilly, Richard J.....25336 Castlereigh, Farmington 48024
Limia, Antonio G...25 Martell Dr., Bloomfield Hills 48013
Ling, T. W.....23607 Farmington Rd., Farmington 48024
Linn, Herman J...3601 W. 13 Mile Rd., Royal Oak 48072
Liu, Henry Y...16001 W. Nine Mile Rd., Southfield 48075
Longyear, Harold W..............3535 W. 13 Mile Rd., Royal Oak 48072
Lovell, James R. (A)........3601 W. Thirteen Mile Rd., Royal Oak 48072
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Lyons, Robt. T.............35 S. Johnson, Pontiac 48053
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Manz, Howard N.............23023 Orchard Lake Rd., Farmington 48024
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Markley, John M.....4120 Sandylane, Birmingham 48010
Maroko, Simon W.........2416 Avondale, Pontiac 48053
Marra, John J..............35 S. Johnson, Pontiac 48053
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Mayo, W. E. Barry............2338 N. Woodward Ave., Royal Oak 48073
Mayor, Raymond L.........35 S. Johnson, Pontiac 48053
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McCallon, Talmage D..............1307 S. Washington, Royal Oak 48067
McCandliss, D. H..........35 S. Johnson, Pontiac 48053
McConkie, James P...............2425 W. Lincoln Rd., Birmingham 48009
McDonald, Robert J............4200 N. Woodward Ave., Royal Oak 48072
McElroy, Wm. J., Jr...4520 Robinwood, Royal Oak 48073
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McGibbon, Bernard M. (A)........900 Woodward Ave., Pontiac 48053
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McInerney, Thos. S......2026 Laurome, Royal Oak 48073
McIntyre, Jack B..........625 Purdy, Birmingham 48009
McKinney, Roy J.................3535 W. 13 Mile Rd., Royal Oak 48072
McLaughlin, J. H................604 North Woodward, Birmingham 48011
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Nathanson, Milton L..............17000 W. 8 Mile Rd., Southfield 48075
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Ports, Preston W. . .33108 Grand River, Farmington 48024
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Reilly, Richard C......909 Woodward Ave., Pontiac 48053
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Reutter, Carolyn..............17600 Northland Pk. Ct., Southfield 48075
Richard, Robert E.....1719 Crooks Rd., Royal Oak 48067
Richards, Wilson P.................3500 W. Maple Rd., Birmingham 48010
Richardson, Robt. P.................26711 Woodward, Huntington Woods 48070
Riggs, Harry L.........149 Franklin Blvd., Pontiac 48053
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Risk, Wm. R...................1190 East 12 Mile Road, Madison Heights, Mi. 48071
Rivas, Ricardo A. (A).............Pontiac State Hosp., Pontiac 48053
Rivera, Eduardo......900 Woodward Ave., Pontiac 48053
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Romanik, John H.................31601 W. 13 Mile Rd., Farmington 48024
Romero, Lino A...............1880 S. Woodward Ave., Birmingham 48009
Rossin, Herbert W. . .20905 Greenfield Rd., Southfield 48075
Roth, Herbert J. . .17640 W. 12 Mile Rd., Southfield 48075
Roumell, Theodore L............444 W. University Dr., Rochester 48063
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Ruesink, Donald E........127 Ferndale, Rochester 48063
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Rush, Alva D., Jr.......391 Hamilton, Birmingham 48011
Ruskin, David S. . .20905 Greenfield Rd., Southfield 48075
Russell, Vincent P. . .3535 W. 13 Mile Rd., Royal Oak 48072
Rutzky, Julius. . . .St. Joseph Mercy Hosp., Pontiac 48053

Ruva, Jos. J.......4463 Dixie Hwy., Drayton Plains 48020
Rydesky, Merle F.....16001 W. 9 Mile, Southfield 48075
Sadovsky, Vincent J...880 Woodward Ave., Pontiac 48053
St. John, Harold A. (L)..35 West Huron St., Pontiac 48058
Salisbury, Carolyn S...21580 Greenfield, Oak Park 48237
Samborski, Anne H..32600 Grand River, Farmington 48024
Samet, Norman T.............1100 N. Woodward Ave., Birmingham 48011
Sandhu, Manmohan S. (A)........900 Woodward Ave., Pontiac 48053
Sanford, Glenn A...........35 S. Johnson, Pontiac 48053
Sansone, Thos J......909 Woodward Ave., Pontiac 48053
Satersmoen, Theodore....524 Riker Bldg., Pontiac 48058
Schaefer, Wm. C.........14001 Greenfield, Detroit 48227
Schirle, Jos. L., Jr.......1116 Voorheis Rd., Pontiac 48053
Schneyer, Jerome J............25000 W. Ten Mile Rd., Southfield 48075
Schoenfeld, Robt. J...800 S. Adams Rd., Birmingham 48011
Scholes, Danl. R...3535 W. 13 Mile Rd., Royal Oak 48072
Schreier, Leonard..909 S. Woodward Ave., Pontiac 48053
Schrock, Marvin E.......35 S. Johnson St., Pontiac 48053
Schuneman, Howard A..........23760 Woodward Ave., Pleasant Ridge 48069
Schwartz, David................33120 W. Twelve Mile, Farmington 48024
Schwartz, Oscar D.........15901 W. 9 Mile Rd., #620, Southfield 48075
Schweinsberg, Stephen......507 Bemis Rd., Saline 48176
Seaborn, Arthur J...............885 N. Woodward Ave., Birmingham 48009
Segula, Robt. L.............35 S. Johnson, Pontiac 48053
Selman, Robert........500 W. Huron St., Pontiac 48053
Sempere, Chas. R...........35 S. Johnson, Pontiac 48053
Sewell, Geo. R.................411 West Ten Mile Rd., Pleasant Ridge 48069
Shadley, Maxwell L........94 Ottawa Dr., Pontiac 48053
Shea, James Joseph........35 S. Johnson, Pontiac 48053
Sheffield, Loren C. (L)....35 S. Johnson, Pontiac 48053
Sheridan, F. Michael...........1307 S. Washington St., Royal Oak 48067
Shin, Eon.....1100 W. University Dr., Rochester 48063
Siegel, Marvin D.......445 W. Huron St., Pontiac 48053
Siegel, Peter.........880 Woodward Ave., Pontiac 48053
Siegel, Sheldon N. (M).......5956 Westchester Pk. Dr., College Park, Md. 20740
Siffring, Loren W....427 W. University, Rochester 48063
Silberg, Joel J.......16800 Greenfield Rd., Detroit 48235
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Silver, Marvin D. 3535 West 13 Mile Rd., Royal Oak 48072
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Smith, Donald S.........1010 Riker Bldg., Pontiac 48058
Smith, Geo. E.....3535 W. 13 Mile Rd., Royal Oak 48072
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Somerville, Wm. J.............3535 W. 13 Mile Rd., 308, Royal Oak 48072
Sosin, Allen..23023 Orchard Lake Rd., Farmington 48024
Spademan, Loren C..............3535 W. 13 Mile Rd., Royal Oak 48072
Spencer, Lloyd H.............1219 S. Washington Ave., Royal Oak 48067
Spiro, Henry J............27046 Pierce, Southfield 48075
Spoehr, Eugene L. 22832 Woodward Ave., Ferndale 48220
Spohn, Earle W. 324 Washington Sq. Pl., Royal Oak 48067
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Stanley, Wm. F.....1148 S. Woodward, Royal Oak 48067
Starman, Marvin L.........21701 W. 11 Mile Rd., #10, Southfield 48075
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Swickle, Edward F...........17 S. Main, Clawson 48017
Swingle, Norman E...............1775 E 14 Mile Rd., Birmingham 48008
Szappanyos, Bela J.............3325 Burning Bush Rd., Birmingham 48010
Tan, Elaine Hartje....367 Old Perch Rd., Rochester 48063
Tan, King L.........367 Old Perch Rd., Rochester 48063
Tan, Thian Lai.......1490 North Pine, Rochester 48063
Tanay, Antoinette....114 S. Lafayette, Royal Oak 48067
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Trader, Kenneth N.........15901 W. 9 Mile Rd., #720, Southfield 48075
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Tsiatalas, George..4045 W. 13 Mile Rd., Royal Oak 48072
Tubbs, Constance J...........15901 W. Nine Mile Rd., Southfield 48075
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Ulveling, Robert A.......500 W. Huron St., Pontiac 48053
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Vanden Berg, Kenneth......35 S. Johnson, Pontiac 48053
Vander, Seymour A.................20905 Greenfield Rd., Southfield 48075
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Robinson, Wm. G. (A)..............Memorial Hospital, Fatehgarh, U. P., India
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Wood, Merle G. (R)..........19 Courtland, Hart 49420

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H.........Box 223, Ontonagon 49953
Hill, Karl E...........9 Hemlock St., White Pine 49971
Lahti, Carl R...................R. 2, Ontonagon 49953
Pierpont, John............141 Maple, White Pine 49971
Strong, James P.........R. 1, Box 406, Ontonagon 49953

OTTAWA COUNTY MEDICAL SOCIETY (186)

Albers, Robt..............601 Michigan, Holland 49423
Arendshorst, Wm.......601 Michigan Ave., Holland 49423
Beernink, Ernest H. (L)..................Duncan Ct., Grand Haven 49417
Bloemendaal, Dirk C. (L)...351 N. Main, Zeeland 49464
Bloemendal, W. B. (A)...................411 Woodlawn, Grand Haven 49417
Boersma, Vernon L.......121 W. 24th St., Holland 49423
Bonzelaar, Alvin..........144 West 26th, Holland 49423
Bradford, Phillip............87 W. 24th, Holland 49423
Bulthuis, Jerry E......................Jamestown 49427
Chamness, James K.....121 W. 24th Street, Holland 49423
Clark, Nelson H...........17 W. 10th St., Holland 49423
Cook, Carl S............121 W. 24th St., Holland 49423
DeCook, Joseph L...........1021 Central, Holland 49423
Devalois, Bernadine.....766 W. 24th St., Holland 49423
De Vries, Harold G.........30 E. 9th St., Holland 49423
De Vries, Peter J....321 Washington, Grand Haven 49417
De Witt, Donald E.......390 Fairhill Dr., Holland 49423
De Young, Fredk. W.................Spring Lake 49456
Dood, Arnold R.........598 Central Ave., Holland 49423
Dykema, Paul........788 Columbia Ave., Holland 49423
Dykstra, Jerome H..........601 Michigan, Holland 49423
Endean, Donald H......121 West 24th St., Holland 49423
Frieswyk, Melvin J.......241 E. Main St., Zeeland 49464
Gesink, Owen J.........492 Orchard Hill, Holland 49423
Groat, Frank L.....631 Franklin St., Grand Haven, 49417
Hager, Ralph.......................Hudsonville 49426
Hamelink, Marinus H.....700 W. 26th St., Holland 49423
Harms, Herman P.........17 W. 10th St., Holland 49423
Heard, Wm. (R)........504 Park St., Grand Haven 49417
Helbing, Edw. J., Jr.....17 W. 10th Street, Holland 49423
Henderson, Jack A...............1310 Wisconsin Ave., Grand Haven 49417
Hommerson, H. J.............3559 M40, Hamilton 49419
Kearney, Jos. B..........121 W. 24th St., Holland 49423
Kemme, Gerrit J.................R. No. 3, Zeeland 49464
Kitchel, John H......414 Franklin St., Grand Haven 49417
Kitchel, Mary F. S.....P.O. Box 521, Grand Haven 49417
Kools, Wm. C. (L)......194 W. 11th St., Holland 49423
Korpi, Steven......520 Ottawa Ave., Grand Haven 49417
Kuipers, Siebe W.......391 W. 31st Street, Holland 49423
Leppink, Richard A.........601 Michigan, Holland 49423
Mahaney, Robert C....601 Michigan Ave., Holland 49423
McArthur, Peter A...1310 Wisconsin, Grand Haven 49417
Meeuwsen, Bernard....601 Michigan Ave., Holland 49423
Moerdyk, Wm. J. (L)....120 W. 14th St., Holland 49423
Nykamp, Russel R........111 E. Main St., Zeeland 49464
Parker, Phillip L......1181 Univista Dr., Holland 49423
Post, J. Jay..........................Allendale 49401
Rottschaefer, Wm..........601 Michigan, Holland 49423
Rotz, Lloyd........575 Robbins Rd., Grand Haven 49417
Rypkema, Willard M...............22 South 2nd Street, Grand Haven 49417
Schaftenaar, R. H..........86 E. 28th St., Holland 49423
Schmidt, Frederick (M)....................6 Hancock, Ft. Leavenworth, Ks. 66027
Sikkema, Donald E..1310 Wisconsin, Grand Haven 49417
Smit, George J.........601 Michigan Ave., Holland 49423
Stobbelaar, Robt. H...1310 Wisconsin, Grand Haven 49417
Ten Have, Ralph (L)..1030 Orchard, Grand Haven 49417
Ten Pas, Henry W.......293 W. 29th St., Holland 49423
Timmerman, Eugene C...............Coopersville 49404
Vander Berg, Edwin E.....17 W. 10th St., Holland 49423

Van Der Velde, Otto (L)...33 W. 8th St., Holland 49423
Vande Waa, Alfred J.....152 E. Cherry St., Zeeland 49464
Van Kolken, P. J........509 Franklin, Grand Haven 49417
Van Krimpen, Carl E...601 Michigan Ave., Holland 49423
Veenstra, Bernard M.................Grand Haven 49417
Ver Duin, John W...1618 Gladys Ave., Grand Haven 49417
Verkaik, Peter......................Hudsonville 49426
Wang, Charles........14 East 25th Street, Holland 49423
Wassink, Jerome H...........34 E. 33rd., Holland 49423
Wells, Kenneth N...119 W. Savidge St., Spring Lake 49456
Westrate, Warren K.......17 W. 10th St., Holland 49423
Westrate, Wm., Sr. (L)....17 W. 10th St., Holland 49423
Westrate, Wm., Jr.........17 W. 10th St., Holland 49423
Winter, John K.............726 State St., Holland 49423
Winter, Wm. G., Jr.........630 State St., Holland 49423
Yff, John H...........430 W. Lawrence, Zeeland 49464
Yonkman, Fredk. F...58 Pomeroy Rd., Madison, N.J. 07940
Zanstra, Benjamin (O)............3337 Van Buren St., Hudsonville 49426

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L. (R)..........124 S. Jefferson Ave., Saginaw 48607
Albers, Millard J...1227 N. Michigan Ave., Saginaw 48602
Anderson, Wm. K. (L)............845 St. Andrews Rd., Saginaw 48603
App, Robt. G............3422 Davenport, Saginaw 48602
Arnas, George C...1600 N. Michigan Ave., Saginaw 48602
Averill, Walter C...........2110 Morson, Saginaw 48602
Balcueua, Edgar P........2 Chippewa Ct., Saginaw 48602
Barry, Jack L...........5670 Dixie Hwy., Saginaw 48601
Barry, Leroy C...........705 Adams St., Saginaw 48602
Bass, Vernon V..........3322 Davenport, Saginaw 48602
Behme, C. Peter.........5160 Helga Dr., Saginaw 48603
Bellinger, Don H. DDS (A)..............P.O. Box 365, Nakomis, Florida 33555
Bergeon, Michael T..........2115 Bay St., Saginaw 48602
Bertrand, Marc G...1311 N. Michigan Ave., Saginaw 48602
Bishop, Harry M. (R)....P.O. Box 129, Harrisville 48740
Bitner, Leland M...1811 N. Michigan Ave., Saginaw 48607
Blanchard, Gerald E.....GMC Chev. Mtr. Div., Box 1749, Saginaw 48605
Bow, William A.........4987 State Street, Saginaw 48603
Bradley, Edward............4444 State Rd., Apt. 214E, Saginaw 48603
Brender, Friedrich P................Frankenmuth 48734
Briggs, Gordon......350 W. Washington, Hemlock 48626
Bruggers, Laurence 1703 N. Michigan Ave., Saginaw 48602
Bullington, Bert M........2000 Court St., Saginaw 48602
Burnett, Quinter M.........4385 Concord, Saginaw 48603
Busch, Frank J......1731 N. Michigan St., Saginaw 48602
Butler, Milton G...1600 N. Michigan Ave., Saginaw 48602
Cady, Donald J...........2002 Court St., Saginaw 48602
Cady, Fredk. J., Jr...402 S. Jefferson Ave., Saginaw 48607
Cady, Fredk. J. (L)..402 S. Jefferson Ave., Saginaw 48607
Cambridge, V. W......Potter at Jefferson, Saginaw 48607
Cameron, Allan K...1314 S. Jefferson Ave., Saginaw 48601
Campbell, Lloyd A. (R)..............335 Brockway Pl., Saginaw 48602
Caumartin, Hugh T...........1537 S. Washington Ave., Saginaw 48601
Chisena, Peter R...........6221 Dixie, Bridgeport 48722
Clowater, Robert A.............Saginaw County Hosp., Saginaw 48605
Cortopassi, Vital E.............324 S. Washington Ave., Saginaw 48607
Cory, Chas W.........1227 N. Michigan, Saginaw 48602
Cresswell, T. A........1236 N. Michigan, Saginaw 48602
Cullen, Geo. (A)....2529 N. Clinton St., Saginaw 48602
Curts, James H.....1205 N. Michigan Ave., Saginaw 48602
Davenport, Clyde P.........2110 Morson, Saginaw 48602
Derifield, R. S. (A).......25 Bretton Ct., Saginaw 48602
DeYoung, William A...............Central Laboratories, 1100 S. Washington, Saginaw 48601
Dowidat, Raymond W. (A)..608 Westfield, Saginaw 48602
Durman, Donald C. (R)...740 Belair Dr., Saginaw 48603
Ellis, George A.......16 E. Hannum Blvd., Saginaw 48602
Ely, Cecil W...........1820 Janes Ave., Saginaw 48601
Ernst, Arthur R. (R)....Fieldmont, The Plains, Va. 22171
Farley, Albert W.......1013 N. Michigan, Saginaw 48602
Field, E. Malcolm.....1013 N. Michigan, Saginaw 48602
Finger, John E.......29 Brian Scott Place, Saginaw 48602
Fleschner, Thos. E. (R)..7749 Marlette, Birch Run 48415
Forster, Kenneth J.........27 Benton Rd., Saginaw 48602
Galsterer, Edwin C...124 S. Jefferson Ave., Saginaw 48607
Gamon, Adam E., II......2004 Court St., Saginaw 48602
Gardner, Joe H.....815 N. Michigan Ave., Saginaw 48602
Gerard, Roy J...........2419 Mackinaw, Saginaw 48602
Gilmore, Robt. D.........234 W. Saginaw, Merrill 48637
Goldner, Richard D.....1024 N. Michigan, Saginaw 48602
Gomon, Louis D...1203 N. Michigan Ave., Saginaw 48602
Goodsell, John O.......1600 N. Michigan, Saginaw 48602
Goodsell, J. Orton, DDS (A)......1305 S. Ocean Blvd., Box 2854, Pompano Beach, Fla. 33062
Goodwin, J. E..1600 N. Mich. Ave., #301, Saginaw 48602
Grant, Michael............101 Marcy, St. Charles 48655
Grundy, Betty Lou....4725 Century Dr., Saginaw 48603
Gugino, George J...........1941 Gate St., Reese 48757
Hand, Eugene A......126 N. Franklin St., Saginaw 48607
Harris, Geo. P.....Saginaw General Hosp., Saginaw 48602
Harvie, Lloyd C. (L)..........330 S. Washington Ave., Saginaw 48607
Hausler, Richard C......206 S. Webster, Saginaw 48602
Heavenrich, Robt. M....1107 Gratiot Ave., Saginaw 48602
Heilbronn, Duane B....1703 N. Michigan, Saginaw 48602
Heinmiller, E. C...Saginaw Gen. Hospital, Saginaw 48605
Helmkamp, Herbert O.....333 S. Jefferson, Saginaw 48607
Hereza, Valeriano D......2125 Bay Street, Saginaw 48602
Herlihy, Mary............101 Marcy, St. Charles 48655
Heuschele, Richard P...1909 Coolidge St., Saginaw 48603
Hill, Victor, Jr.....1703 N. Michigan Ave., Saginaw 48602
Hines, Ronald G......St. Marys Hospital, Saginaw 48605
Hoban, Sean J. (A)..............1232 N. Michigan Ave., Saginaw 48602
Hubinger, H. L., D.D.S. (A)...501 2nd Natl. Bnk. Bldg., Saginaw
Hunt, Maurice E........5000 Maple St., Fairgrove 48733
Hyslop, Wm. T.........1610 Gratiot Ave., Saginaw 48602
Iizuka, Reiichi............69 Benton Rd., Saginaw 48602
Infante, A..............1931 E. Genesee, Saginaw 48601
James, John W.......1021 W. Genesee St., Saginaw 48607
Jardinico, Robert........3 Center Woods, Saginaw 48603
Jarvi, Rudolph M.......1107 Gratiot Ave., Saginaw 48602
Johnson, G. T. (A)........V.A. Hospital, Saginaw
Johnstone, Kermit T.....1050 Fisher Dr., Saginaw 48601
Jordan, Leo A........1524 E. Genesee St., Saginaw 48607
Kelly, Michael V...1811 N. Michigan Ave., Saginaw 48602
Kerr, Wm. B.........300 S. Michigan St., Saginaw 48602
Kershul, Victor W..................314 Graebner Bldg., 120 N. Michigan Ave., Saginaw 48602
Keyes, James T.......10222 Maple Rd., Birch Run 48415
Kickham, Edward F.......705 Adams St., Saginaw 48602
Kleekamp, Herbert G. (R)......1776 S. Rogers Rd., R. 1, Clare 48617
Kleinschmidt, Earl E.....3625 Webber St., Saginaw 48601
Kolesar, Robt. C............1005 Gratiot, Saginaw 48602
Koucky, Charles J.......14 Center Woods, Saginaw 48603
Kowals, Francis V. (R)......Med. Dir. Chec. Ser. G.M.C., Saginaw 48603
Kretschmer, Thos. V.............1232 N. Michigan Ave., Saginaw 48602
Labsan, H. F......1803 N. Michigan Ave., Saginaw 48602
Lassignal, Jules C...1600 N. Michigan Ave., Saginaw 48602
Lepperd, F. C., Jr. (A)....1500 Weiss St., Saginaw 48602
Lian, Teck S...........518 Eleanor Ave., Saginaw 48602
Ling, Kenneth C.......................Hemlock 48626
Loftin, Robert L......1501 N. Michigan, Saginaw 48602
Lohr, Thos. O.....1135 N. Michigan Ave., Saginaw 48602
Love, Neil W.......505 W. Tuscola, Frankenmuth 48734
Lurie, Robt. I...2525 S. Washington Ave., Saginaw 48601
Mahaney, Thos. P.......3521 State Street, Saginaw 48602
Manning, John E...815 N. Michigan Ave., Saginaw 48602
Manning, John W., III........705 Adams, Saginaw 48602

Markey, Francis L......1600 N. Michigan, Saginaw 48602
Martin, Jack F.....1011 N. Michigan Ave., Saginaw 48602
Martzowka, Wm. P....415 W. Genesee St., Saginaw 48602
Mason, Wm. G.........1107 Gratiot Ave., Saginaw 48602
Matthews, Harry C..............1227 N. Michigan Ave., Saginaw 48602
Mayne, Harold E......2111 Marshall Ct., Saginaw 48602
McEwen, Wm. G..........1502 Court St., Saginaw 48602
Meyer, Henry J. (L)..6243 Dixie Hwy., Bridgeport 48722
Mikan, V. Robert......3900 Holland Rd., Saginaw 48601
Miller, Glenn F...........2224 Mershon, Saginaw 48602
Moeser, Ulrich.........1447 N. Harrison, Saginaw 48602
Moon, A. Raymond (L)..705 Sunset Lane, Cadillac 49601
Mooney, James C...1600 N. Michigan Ave., Saginaw 48602
Morgrette, Leonard J.....3424 Davenport, Saginaw 48602
Mudd, Richard D. (R)....1001 Hoyt St., Saginaw 48607
Mulhern, Donal T...2716 S. Jefferson Ave., Saginaw 48607
Murphy, Albert P...303 N. Michigan Ave., Saginaw 48602
Murphy, Richard T., D.D.S. (A)......1718 N. Michigan, Saginaw 48602
Murray, Morris J.........3424 Davenport, Saginaw 48602
Nelson, Oscar A.........3324 Davenport, Saginaw 48602
Nese, T. S..............830 S. Jefferson, Saginaw 48601
Noble, Paul R..........1447 N. Harrison, Saginaw 48602
Northway, Robt. O.....1811 N. Michigan, Saginaw 48602
Novy, Frank O. (L)..420 S. Jefferson Ave., Saginaw 48607
Obregon, Carlos......2805 Germain Dr., Saginaw 48601
Olson, Carl P. (A)................122 Morningside Dr., Battle Creek 49015
Packer, James E...........5230 State St., Saginaw 48603
Patrick, Susan J...........715 Fifth St., Baldwin 49304
Perea, Manuel M........599 N. Frost Dr., Saginaw 48603
Phillips, Homer A......1600 N. Michigan, Saginaw 48602
Powers, Robt. F........1600 N. Michigan, Saginaw 48602
Prather, Perry E......1227 N. Mich. Ave., Saginaw 48602
Prinsell, Gustave G. (M).........Houghton, N.Y. 14774
Rank, J. Eugene.......1107 Gratiot Ave., Saginaw 48602
Reichman, Jos. J...........1455 Sheffield, Saginaw 48605
Reimers, Gerald F.......4046 Hess Street, Saginaw 48601
Rice, William T....1827 N. Michigan Ave., Saginaw 48602
Richards, Ned W..........3518 State St., Saginaw 48602
Richter, Harry J. (R)..1401 W. Delta Dr., Saginaw 48603
Roggen, Ivan J.........1227 N. Michigan, Saginaw 48602
Ruskin, Dave B.........1600 N. Michigan, Saginaw 48602
Ryan, Richard S...1581 S. Washington Ave., Saginaw 48601
Sargent, Donald V. 1703 N. Michigan Ave., Saginaw 48602
Sarmiento, G. A...1600 N. Michigan Ave., Saginaw 48602
Schneider, A. J. N....509 S. Jefferson Ave., Saginaw 48607
Schultz, Frank R......243 W. Broad St., Chesaning 48616
Scott, Gerard..........5670 Dixie Hwy., Saginaw 48601
Sharp, Martin C...1803 N. Michigan Ave., Saginaw 48602
Shek, John L..........803 N. Michigan, Saginaw 48602
Sheldon, Suel A. (L).....124 S. Jefferson, Saginaw 48607
Sherman, John W.........403 S. Fayette, Saginaw 48602
Simms, Uca Frances......5707 Evergreen, Midland 48640
Skowronski, C. A.....1401 E. Genesee St., Saginaw 48607
Slade, Homer G....1520 N. Michigan Ave., Saginaw 48602
Spengler, Donald E., D.D.S. (A)......4481 Bradford Dr., Saginaw 48603
Stander, Aaron C..........1411 Court St., Saginaw 48602
Sulfridge, Hugh L., Jr...........1011 N. Michigan Ave., Saginaw 48602
Talbot, Joseph E...1311 N. Michigan Ave., Saginaw 48602
Taylor, Robert E.......1447 N. Harrison, Saginaw 48602
Thompson, Arthur B......2144 Ottawa St., Saginaw 48602
Tiedke, Gunther E...120 N. Michigan Ave., Saginaw 48602
Toteff, Robert J...........2110 Morson, Saginaw 48602
Tramitz, Melvin E......711 Somerset Rd., Saginaw 48603
Tuttle, Terence K.........1109 Court St., Saginaw 48602
Underhill, Wm. G...........8 Five Oaks, Saginaw 48603
Villegas, Alfonso A...1232 N. Mich. Ave., Saginaw 48602
Vincent, John H......4158 Atwood Ln., Bridgeport 48722
Vitu, Robert L..........703 W. Genesee, Saginaw 48602
Volk, Vladimir K. (L)........Saginaw Co. Hosp., Box 65, Saginaw 48605
Waite, Barry F...........403 S. Fayette, Saginaw 48602
Walsh, Peter R...........331 S. Jefferson, Saginaw 48607
Webb, Lester E............1500 Gratiot, Saginaw 48602
Weiss, Arno W............3521 State St., Saginaw 48602
Westlund, Norman........3253 Congress, Saginaw 48602
Woomer, Donald F..............1227 N. Michigan Ave., Saginaw 48602
Wright, Edwin M......1311 N. Michigan, Saginaw 48602
Yntema, Stuart (L)........51 Davis Dr., Saginaw 48602
Young, John.............705 Cooper St., Saginaw 48602

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S.......2425 Military St., Port Huron 48060
Balboa, Ronaldo S.......St. Clair Clinic, St. Clair 48079
Banting, Kenneth C..............403 Peoples Bk. Bldg., Port Huron 48060
Barss, J. A............1209 Tenth St., Port Huron 48060
Battley, John C. S. (L)..1216 6th St., Port Huron 48060
Beck, Frank K..........2902 Military, Port Huron 48060
Beer, Jos. F.......104 N. Riverside Ave., Saint Clair 48079
Bennett, Wm. G.............210 S. Main St., Yale 48097
Blatter, Erwin W.....3864 Gratiot Ave., Port Huron 48060
Borden, Chas. L........236 Huron Ave., Port Huron 48060
Bottomley, Thos. H., Jr...1102 Sixth St., Port Huron 48060
Boughner, Walter H......325 Pleasant St., Algonac 48001
Bovee, Marion E. (L)..2208 Stone St., Port Huron 48060
Bowden, Wm. S......130 Washington, Marine City 48039
Bridge, Ezra V.......416 Edison Blvd., Port Huron 48060
Burke, Colman J.........................311 Pine St., Port Huron 48060
Candler, Clarence L. (L)..815 Brown St., St. Clair 48079
Cantwell, John D., Jr.....2425 Military, Port Huron 48060
Chafty, Mahmoud.......2425 Military, Port Huron 48060
Cleland, Wm. D., Jr. Medical Arts Bldg., Port Huron 48060
Clifford, Robt. P.....506 S. Riverside Dr., St. Clair 48079
Clyne, Benj. C..............103 N. Main St., Yale 48097
Coury, John J., Jr.......1209 Tenth St., Port Huron 48060
Davison, Wm. T......2425 Military St., Port Huron 48060
Dinnen, Wm. J., Jr.......2425 Military, Port Huron 48060
Douvas, Nicholas G.......4200 Gratiot, Port Huron 48060
Dupuis, Jean Paul.....1502 Shumaker, Port Huron 48060
Escalera, Gustavo (A)..........1605 Fred Moore Hwy., St. Clair 48079
Fenton, Edwin H...906 St. Clair River Rd., Algonac 48001
Fitzgerald, E. W., Jr.....1102 Sixth St., Port Huron 48060
Franke, Armin T........2425 Military, Port Huron 48060
Fuerst, Erwin J.......1322 N. River Rd., St. Clair 48079
Fulton, Harold E., Jr...2425 Military St., Port Huron 48060
Gerrits, James F..........St. Clair Clinic, St. Clair 48079
Gholz, Anthony C...Medical Arts Bldg., Port Huron 48060
Gilmore, John R...317 Mich. Bank Bldg., Port Huron 48060
Gonzalez, Carlos F.....1605 Division Rd., St. Clair 48079
Hazledine, H. J.....4685 Lakeshore Rd., Port Huron 48060
Hislop, David M. C...............5076 Lake Shore Rd., Port Huron 48060
Hlivko, Alexander E..........1605 Fred W. Moore Hwy., St. Clair 48079
Hodgins, Thomas E. (A)..............3540 Lapeer Ave., Port Huron 48060
Holcomb, Russell J......140 S. Market, Marine City 48039
Hoyt, Chas. N.........1501 Krafft Rd., Port Huron 48060
Johnston, Thomas C...2425 Military St., Port Huron 48060
Kahn, Oscar B...........................Capac, 48014
Kirban, Harry N...5500 Lakeshore Rd., Port Huron 48060
Kirker, J. G. (L)...626 Busha Highway, Marysville 48040
Koch, Donald A.......2425 Military St., Port Huron 48060
Kostoff, Harold R.......310 Water St., Port Huron 48060
Lauridsen, James........621 River St., Port Huron 48060
Le Galley, K. B. (A).............6942 E. Exeter Blvd., Scottsdale, Az. 85251
Licker, Reuben R.....2425 Military St., Port Huron 48060
Ludwig, Claude A.....916 Seventh St., Port Huron 48060
Ludwig, Fredk. E.........916 7th St., Port Huron 48060
Lugg, Robt. M...........619 River St., Port Huron 48060
Mayhew, Harry E....613 N. Riverside Dr., St. Clair 48079
Meza, Pedro........1105 Sedgwick St., Port Huron 48060
Miller, John M......1010 Griswold St., Port Huron 48060
Mohney, Glenn E........1131 Erie St., Port Huron 48060

Morris, Alvin N.........621 River St., Port Huron 48060
Neruda, Fred..........640 N. Third St., St. Clair 48079
Novak, Walter S.....310 E. Water St., Port Huron 48060
Olivera, Juan E.....2425 Military St., Port Huron 48060
Patterson, Dorsey W. (L).............622 Huron Ave., Port Huron 48060
Raftery, Michael.......2425 Military, Port Huron 48060
Relken, Richard C...2920 Pine Grove, Port Huron 48060
Rowe, Robt. E....108 McMorran Blvd., Port Huron 48060
Rutledge, John J. (A)..............2205 Standish Court, Port Huron 48060
Sabbagh, Michael I..........1605 Fred W. Moore Hwy., St. Clair 48079
Sanderson, Jos. L.........515 Pine St., Port Huron 48060
Schaefer, Waldo A...............302 Mich. Bank Bldg., Port Huron 48060
Serniak, John A.............104 S. Main St., Yale 48097
Sharpe, James W....310 E. Water St., Port Huron 48060
Shoudy, Elmore D.....902 Tenth Ave., Port Huron 48060
Snider, James J.........2425 Military, Port Huron 48060
Tisdel, James H......310 E. Water St., Port Huron 48060
Tomsu, Glenn F.......310 E. Water St., Port Huron 48060
Townley, Chas. O......1209 Tenth St., Port Huron 48060
Treadgold, Douglas (A)..............1323 Military St., Port Huron 48060
Ulmer, Arthur H., Jr....1209 Tenth St., Port Huron 48060
Walker, Sidney C......1209 Tenth St., Port Huron 48060
Ware, J. Raleigh (R)....3107 24th St., Port Huron 48060
Webb, Gordon H......1322 N. River Rd., St. Clair 48079
Weckesser, W. C........1602 Military, Port Huron 48060
Wilhelm, Daniel J.....619 River Street, Port Huron 48060
Yost, Kenneth W.....1305 Gratiot Ave., Marysville 48040
Youngs, John A. .....718 Griswold St., Port Huron, 48060
Yull, Arthur B.........1209 Tenth St., Port Huron 48060

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A......106 E. Chicago Rd., Sturgis 49091
Bradley, D. E..............234 S. Main St., Colon 49040
Braham, Wilbur G.........111 S. Monroe, Sturgis 49091
Brothers, Paul L....1313 Rolling Ridge Ln., Sturgis 49091
Brunson, Allen E..........206 E. West St., Sturgis 49091
Dettman, Harold.........Maplecrest Plaza, Sturgis 49091
Evans, Robt. H..........111 S. Monroe St., Sturgis 49091
Fiegel, S. Albert...........111 S. Monroe, Sturgis 49091
Fortner, Roscoe J....137 Portage Ave., Three Rivers 49093
Gillespie, Eleanor M. (A)..........173 Waban Hill Rd., Newton, Ma. 02167
Hill, Robert V...............1500 N. Main St., Box 171, Three Rivers 49093
Jacobowitz, John M..................Lincoln at Millard, Three Rivers 49093
Lepard, Olin L........Knollwood Dr., R. 1, Sturgis 49091
Lewis, Robert........104 S. Lakeview St., Sturgis 49091
McCullough, Hugh......111 S. Monroe St., Sturgis 49091
O'Dell, Charles W.....117 Spring St., Three Rivers 49093
O'Dell, John H., Jr..................Three Rivers 49093
Olney, Frank (A)....................Centerville 49032
Pennington, Harry C.................118 S. Kalamazoo, White Pigeon 49099
Penzotti, Stanley C.....117 Spring St., Three Rivers 49093
Porter, Clark G..........226 East St., Three Rivers 49093
Schimnoski, D. R..............Three Rivers Med. Clnc., Three Rivers 49093
Shaw, Geo. D.........117 Spring St., Three Rivers 49093
Sheldon, John P...........206 E. West St., Sturgis 49091
Smith, Robt. D..........................Colon 49040
Weisheit, H. R...................Route 1, Sturgis 49091
Zimont, Chas. R......................Constantine 49042
Zimont, Raymond D.................Constantine 49042

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R.......................Marlette 48453
Duvall, Dorothy......817 Patterson Ave., Bay City 48706
Ellis, Larry G.........426 W. Speaker, Sandusky 48471
Ford, Frances A. (L)...........2683 S. Lakeshore Rd., Applegate 48401
Gariepy, Bernard F..................Deckerville 48427
Gift, Weldon A. (L)....................Marlette 48453
Groat, Gerald........................Deckerville 48427
Hart, Robt. K. (L)....................Croswell 48422
Jayson, Michael H......2764 Lorraine St., Marlette 48453
McCrea, John W.......................Marlette 48453
McGunegle, Keate T...................Sandusky 48471
Muir, Neil............................Croswell 48422
Seager, M. Cole.....................Brown City 48416
Smith, Duane E......................Brown City 48416
Tweedie, G. Evans....................Sandusky 48471
Tweedie, S. Martin...................Sandusky 48471
Webster, J. C. (L)....................Marlette 48453
Winfield, Raymond J........3014 Main St., Marlette 48453

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L., Jr. (L).............R. 1, Ovid 48866
Austin, Eugene S............1260 Ada St., Owosso 48867
Bach, Norman F..........113 E. Williams, Owosso 48867
Bjarnesen, Walter (A)................7518 Hamlet St., North Springfield, Va. 22151
Brown, Richard C.....113 E. Williams St., Owosso 48867
Buzzard, Walter D........................Chesaning 48616
Cameron, Richard R...........San Antonio State Hosp., 5900 South Presa, San Antonio, Tx. 78223
Chapman, Daniel....825 Packard Rd., Ann Arbor 48104
Chipman, Elwood M. (R)..........502 W. Williams St., Owosso 48867
Clifford, Robert..........Matthews Bldg., Owosso 48867
Foerster, Alfred W.....113 E. Williams St., Owosso 48867
Ford, Wm. J. A., Jr....113 E. Williams St., Owosso 48867
Forsyth, Henry T.....137 S. Saginaw St., Chesaning 48616
Graves, James H.........511 W. Main St., Owosso 48867
Gurden, Elizabeth A. L.............113 E. Williams St., Owosso 48867
Harroun, John E...........323 N. Ball St., Owosso 48867
Harroun, R. V.............323 N. Ball St., Owosso 48867
Hofstra, John..........................Owosso 48867
Hoshal, Verne L..........104 W. Clinton, Durand 48429
Kennedy, John J........1626 N. Chipman, Owosso 48867
Lipsey, Donald.........................Durand 48429
MacGregor, John F.....113 E. Williams St., Owosso 48867
McGeehan, J. S...........Matthews Bldg., Owosso 48867
McKnight, Edwin R..............320 N. Washington St., Owosso 48867
Merz, Walter L...............307 N. Ball, Owosso 48867
Moore, Phillip J..........221 E. North St., Owosso 48867
Morovitz, John E.........113 E. Williams, Owosso 48867
Park, James H............812 Bradley St., Owosso 48867
Phillips, Rolland..........Matthews Bldg., Owosso 48867
Richards, Chester J. (L) 101 E. Monroe St., Durand 48429
Roty, Robert L. (M)......Matthews Bldg., Owosso 48867
Sahlmark, Jos. F..........812 Bradley St., Owosso 48867
Sauer, Peter.............113 E. Williams, Owosso 48867
Shepherd, Walter F. (R)......Box 148, Coldwater 49036
Trick, O. L. (A)...Duke University, Durham, N.C. 27706
Weinkauf, Wm. F. (L)................Corunna 48817
Weston, Claude L. (L)....Matthews Bldg., Owosso 48867
Wickstrom, Geo. B.........529 Clark Ave., Owosso 48867
Yun, Bo Sup..............826 W. King, Owosso 48867

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Anderson, Norma.............206 Ellington, Caro 48723
Ballard, James H.......................Cass City 48726
Chapin, Maurice H....................Millington 48746
Cole, Versa V..................Lock Box A, Caro 48723
Dickerson, Willard W. (R)..Caro State Hosp., Caro 48723
Donahue, Harold T.........4674 Hill St., Cass City 48726
Elmendorf, E. N., II......................Vassar 48768
Flett, Richard O.......................Millington 48746
Gokcora, Nurettin B..........Caro St. Hosp., Caro 48723
Howlett, Robt. R.......................Star Rte. 221A,
McMasters Bridge Rd., Grayling 49738
Kovacs, Geza.............861 Gilford Road, Caro 48723
Merrill, Elmer H............506 Gilford Rd., Caro 48723
Miles, Edward J...........................Caro 48723
Nigg, Herbert L...........................Caro 48723
Savage, Lloyd L. (L).............5208 Port Austin Rd.,
Caseville 48725
Schurter, Bettye S. C.......Caro State Hosp., Caro 48723
Swanson, Ewald C............220 N. Main, Vassar 48768
Urban, Mitchell...........Caro State Hosp., Caro 48723
Von Renner, Otto (L)........P.O. Box 396, Reese 48757

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F.......................Hartford 49057
Boothby, Fredk. M....................Lawrence 49064
Boyd, Wayne R........Route 4, Box 307, Paw Paw 49079
Cooper, Jos. E.........417 W. Monroe St., Bangor 49013
Davis, James M........424 Huron St., South Haven 49090
Diephuis, Bert........511 Huron St., South Haven 49090
Dillon, Thos. J. (A)....240 S. Eudora, Denver, Co. 80220
Gano, Avison.............417 Monroe St., Bangor 49013
Itzen, John F..........P.O. Box 485, South Haven 49090
Kleber, John A........365 Broadway, South Haven 49090
Lawther, John............P.O. Box 191, Hartford 49057
Loomis, Frank J.......................Paw Paw 49079
Lukaszek, Henry J. 77 N. Shore Drive, South Haven 49090
McFadden, Roscoe I................RFD #1, Box 83,
Bloomingdale 49026
Millard, David.......................Paw Paw 49079
Morgan, Dale K......403 Phoenix St., South Haven 49090
Parks, Arthur E........................Lawton 49065
Spalding, R. W..............P.O. Box 280, Gobles 49055
Stagg, Adelbert L.........9 N. Maple St., Hartford 49057
Stagg, G. Lee.................Box 307, Hartford 49057
Stagg, Ruth E. A...............Box 38, Hartford 49057
Sundin, Paul W. (A)......106 E. First St., Monroe 48161
Ten Houten, Charles..................Paw Paw 49079
Terwilliger, Edwin H...P.O. Box 110, South Haven 49090
Urist, Martin J.............Route 5, South Haven 49090
Witte, David B.............Route 3, South Haven 49090
Young, Wm. R. (L)....................Lawton 49065

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Abell, Murray R..1335 E. Catherine St., Ann Arbor 48104
Alexander, Don K.....301 N. Ingalls St.. Ann Arbor 48104
Alford, Barry H.............385 N. Mill, Plymouth 48170
Allen, Richard J.....University Hospital, Ann Arbor 48104
Allis, Lyle M...2355 E. Stadium Blvd., Ann Arbor 48104
Anderson, David G........2490 Adare, Ann Arbor 48104
Anderson, Gerhard D. (A).........9500 E. Orchard Dr.,
Englewood, Co. 80110
Anderson, Robt. E.....2136 S. Seventh, Ann Arbor 48103
Apostolakis, J. L. (A)..............Dept. of Radiology,
University Hospital, Ann Arbor 48104
Atchison, Russell M.....501 W. Dunlap, Northville 48167
Ause, Robert G..........1821 Sheridan, Ann Arbor 48104
Badgley, Carl E. (L).....2100 Hill St., Ann Arbor 48104
Bailey, Robt. W.......University Hosp., Ann Arbor 48104
Baird, Walter M...2558 Old Boston Ct., Ann Arbor 48104
Baker, Dale E..St. Joseph Mercy Hosp., Ann Arbor 48104
Bandera, Emily A.......P.O. Box 1047, Ann Arbor 48106
Bandera, Jaroslav M...........4200 E. Huron River Dr.,
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Banghart, Norman L...............1950 Manchester Rd.,
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Barker, Paul S. (R)......Box 87, Bonnots Mill, Mo. 65016
Barlow, R. Craig.....326 N. Ingalls St., Ann Arbor 48104
Barron, Walter L.......2201 Delaware, Ann Arbor 48103
Barry, Alexander, Ph.D. (A)....Med. Sc. Bldg., U. of M.,
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Barss, Wm. A...........525 W. Cross St., Ypsilanti 48197
Bartholomew, Lee E...........4633 Kresge Bldg., U. M.,
Ann Arbor 48104
Bass, Thos. J............201 S. Hamilton, Ypsilanti 48197
Bassow, Paul H........St. Joseph Hosp., Ann Arbor 48104
Bauer, Gerhard H...2015 Manchester Rd., Ann Arbor 48104
Bauer, Jere M.........1313 E. Ann St., Ann Arbor 48104
Behrman, Saml.....2866 Provincial Dr., Ann Arbor 48104
Beierwaltes, Wm. H..............U. M. Medical Center,
Ann Arbor 48104
Beison, Richard A....1795 W. Stadium, Ann Arbor 48103
Bell, Margaret (L)...............1107 E. Adelaide Dr.,
Tucson, Az. 85719
Belser, Walter...2310 E. Stadium Blvd., Ann Arbor 48104
Bender, Leonard F.....1313 E. Ann St., Ann Arbor 48104
Benson, Paul J., Jr...227 N. Sheldon Rd., Plymouth 48170
Benson, Ronald M. (A)...........1053 Island Drive Ct.,
Ann Arbor 48105
Bentley, Fredk. E.......851 S. Main St., Plymouth 48170
Bicknell, John N...703 First Natl. Bldg., Ann Arbor
Blair, Albert J., Jr......1739 Sheridan, Ann Arbor 48104
Boblitt, Delbert E.....2112 Wallingford, Ann Arbor 48104
Bogard, William J. (A)..........Box A, Ypsilanti 48197
Boles, Roger............4785 Lake Ct., Ann Arbor 48103
Borocz, Istvan (M)..USAF Hosp., Wright Patterson AFB,
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Botsford, James H.........775 S. Main St., Chelsea 48118
Boudeman, John E. (A)........St. Joseph Mercy Hosp.,
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Bourne, Charles W. (M)..............208 E. Wisconsin,
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Brandl, Earl A.......Hydromatic Division, Ypsilanti 48197
Brandt, Ralph L.........326 N. Ingalls, Ann Arbor 48104
Breakey, Barry A........2216 Medford, Ann Arbor 48104
Brewer, Wilson K. (R) 4255 Washtenaw, Ann Arbor 48104
Britt, Eugene M., Ph.D. (A)........1411 Bardstown Tr.,
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Brougher, Robert H.................1100 W. Huron St.,
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Brovins, Walter G...Ypsilanti State Hosp., Ypsilanti 48197
Brown, Philip N. (R)...1403 Division Dr., Milford 48042
Brown, Wm. E., III..2101 Belmont Rd., Ann Arbor 48104
Bryan, George C..........2547 Ellis Rd., Ypsilanti 48197
Bryant, H. C.......425 E. Washington, Ann Arbor 48108
Bucalo, Harry D., Jr....2207 S. Seventh, Ann Arbor 48103
Buchanan, Robert A.....2715 Brockman, Ann Arbor 48104
Burke, Dennis R.........125 Harper Drive, Saline 48176
Bush, Jack L.....1950 Manchester Rd., Ann Arbor 48104
Butler, Gerald E...2311 E. Stadium Blvd., Ann Arbor 48104
Cameron, George H....2311 E. Stadium, Ann Arbor 48104
Cameron, Hugh A...............425 E. Washington St.,
Ann Arbor 48108
Campbell, Darrell A.......617 Stratford, Ann Arbor 48104
Candell, Antimo.......2318 Medford, Ann Arbor 48104
Canty, Charles (A)....2347 Yost Blvd., Ann Arbor 48104
Capili, A. M..........14 N. Hamilton St., Ypsilanti 48197

Capili, E. Esquejo.....14 N. Hamilton St., Ypsilanti 48197
Carbeck, Robt. B.........3080 Exmoor, Ann Arbor 48104
Carroll, Catherine........1130 Hill St., Ann Arbor 48104
Carron, Dean P.....425 E. Washington, Ann Arbor 48108
Carter, Thomas L. (A)..........2131 Georgetown Blvd., Ann Arbor 48105
Cassidy, James T.........590 Lansway, Ann Arbor 48103
Cerny, Joseph C...University Med. Ctr., Ann Arbor 48104
Chatas, George J....2984 Hickory Lane, Ann Arbor 48104
Chesky, Robert H.....1130 Hill Street, Ann Arbor 48104
Child, Chas. G., III..University Hospital, Ann Arbor 48104
Claeys, Eugene F...........775 S. Main, Chelsea 48118
Clague, Allan G.....1743 Waltham Dr., Ann Arbor 48103
Clifford, Mary Ellen..University Hospital, Ann Arbor 48104
Clyde, Ensign E.......1181 S. Main St., Plymouth 48170
Coe, Robert O. (A)..University Hosp., Ann Arbor 48104
Cohan, Bruce E...2355 E. Stadium Blvd., Ann Arbor 48104
Conn, Jerome W...200 Orchard Hill Dr., Ann Arbor 48104
Copping, James W., Jr. (A)...........2757 Canterbury, Ann Arbor 48104
Courtney, Kenneth O.....2119 Melrose, Ann Arbor 48104
Courtney, N. Warn (A)........823rd Med. Group, AFB, Homestead, Florida 33030
Cox, Morton S., Jr.....70 E. Waters Rd., Ann Arbor 48103
Crook, Clarence E.............1050 Wall St., Apt. 10A, Ann Arbor 48105
Cross, Thomas N...Univ. Medical Center, Ann Arbor 48104
Curtis, Arthur C. (L)..1313 E. Ann St., Ann Arbor 48104
Curtis, Edward G...............1825 W. Stadium Blvd., Ann Arbor 48103
Davenport, Charles W...........2311 E. Stadium Blvd., Ann Arbor 48104
Davenport, Fred M.....1038 Martin Pl., Ann Arbor 48104
Davey, Paula G.....425 E. Washington, Ann Arbor 48108
Davey, Winthrop N........495 Hillspur, Ann Arbor 48105
Deatrick, Richard W................2940 Hickory Lane, Ann Arbor 48104
de Caires, Percy F. R.....700 Avon Rd., Ann Arbor 48104
De Jong, Russell N...1526 Harding Rd., Ann Arbor 48104
Dekornfeld, Thomas J.............2581 Hawthorn Rd., Ann Arbor 48104
Dell, Thomas A.......2900 Brandywine, Ann Arbor 48104
Delong, Wm. B. (M)...USAF Hospital, Tachikawa, Japan
Demuth, George R......Univ. Hospital, Ann Arbor 48104
Den Houter, W. D.......225 N. Sheldon, Plymouth 48170
De Tar, John S. (L)........55 W. Main St., Milan 48160
Dew, Richard C. 2355 E. Stadium Blvd., Ann Arbor 48104
Diaz Perez, Rodrigo......2939 Renfrew, Ann Arbor
Didelius, D. P. Lt. MC (M)
Dieterich, Gordon C...4038 Jackson Rd., Ann Arbor 48106
Dillman, Richard S......1800 Baldwin, Ann Arbor 48104
Dingman, Reed O.......221 N. Ingalls, Ann Arbor 48104
Dinman, Bertram D...1132 Aberdeen Dr., Ann Arbor 48104
Dodson, Vernon N...............1638 University Hosp., Ann Arbor 48104
Doezema, Edward R. 1111 E. Catherine, Ann Arbor 48104
Dolfin, Wilbur E.........2210 Melrose, Ann Arbor 48104
Domino, Edward F.......3071 Exmoor, Ann Arbor 48104
Dorr, Richard P. (A).............University Hospital, Ann Arbor 48104
Douthat, Rudenz T.....1415 Beechwood, Ann Arbor 48103
Draper, Bruce........2222 Fuller Rd., Ann Arbor 48105
Driver, James R.......155 Underdown, Ann Arbor 48105
Dryer, Clyde K...........3033 Sophia St., Wayne 48184
Dukay, Alexander P......3501 Willis Rd., Ypsilanti 48197
Edmunds, Wm. P.........21 S. Prospect, Ypsilanti 48197
Edwards, Melvin L., Jr. 1210 Maple Rd., Ann Arbor 48103
Eliot, Johan W.....Sch. of Pub. Health, Ann Arbor 48104
Elliott, Lyle D............27 S. Prospect, Ypsilanti 48197
Emmert, Gregor K. (A)....Urology Dept., Univ. Hosp., Ann Arbor 48104
Engelke, Otto K. (L).........313 Washtenaw Co. Bldg., Ann Arbor 48108
Epstein, Jerome L.......27 S. Prospect, Ypsilanti 48197
Fajans, Stefan S.......2485 Devonshire, Ann Arbor 48104
Falk, Elwin C...........14 N. Hamilton, Ypsilanti 48197
Falls, Harold F........University Hosp., Ann Arbor 48104
Farhat, Saeed M..........424 Onaway, Ann Arbor 48104
Fayos, Juan V...University Med. Center, Ann Arbor 48104
Feller, Irving.........2023 Devonshire, Ann Arbor 48104
Fellman, S. L.......2216 Medford Rd., Ann Arbor 48104
Ferrington, R. A...........519 W. Main St., Milan 48160
Finch, Jay S.....51259 Murray Hill Dr., Plymouth 48170
Finch, Stuart M. Child Psychiatric Hosp., Ann Arbor 48104
Fink, Geo. C...........411 Linda Vista, Ann Arbor 48104
Fink, George H. (A)....459 Manor Dr., Ann Arbor 48105
Fischmann, George..1321 Franklin Blvd., Ann Arbor 48103
Fisher, Jos. V...............116 Park St., Chelsea 48118
Fisher, Robert J........21 S. Prospect St., Ypsilanti 48197
Foley, Arthur Lee, II...........2001 Brampton Court A, Ann Arbor 48103
Ford, Jack (M) ....#402, Fort Sanders Prof. Bldg., Knoxville, Tenn. 37916
Fox, Winslow G......715 N. University, Ann Arbor 48104
Fralick, F. Bruce...............D-2137, N. Out Patient, University Hosp., Ann Arbor 48104
Francis, Thos., Jr..............U. Mich. Schl. Pub. Hlth., Ann Arbor 48104
Fransway, Robt. L................2785 Park Ridge Dr., Ann Arbor 48103
French, Arthur B...1405 E. Ann St., W 4642 Univ. Hosp., Ann Arbor 48104
French, A. James....356 Ausable Place, Ann Arbor 48104
Frey, Charles F...3555 Daleview Dr., Ann Arbor 48103
Frohlich, Moses M.....1313 E. Ann St., Ann Arbor 48104
Frost, Lyle W.....309 N. Washington St., Ypsilanti 48197
Frye, Carl M...........301 N. Ingalls, Ann Arbor 48104
Furstenberg, A. C. (L)..............2240 Belmont Rd., Ann Arbor 48104
Gabrielsen, T. O....................Dept. of Radiology, University Med. Center, Ann Arbor 48103
Gall, John C.......2903 Sheffield Ct., Ann Arbor 48105
Garrison, D. E. Lt. MCUSN (M)....117 Buckingham Pl., Brunswick, Ga. 31520
Gates, George A.....3689 Frederick Dr., Ann Arbor 48105
Gerigk, Paul F............250 E. Michigan, Saline 48176
Getting, Vlado A...........Sch. of Pub. Hlth., U. of M., Ann Arbor 48104
Gignac, Ralph M.........32320 Michigan, Wayne 48184
Gikas, Paul W..........1900 Mershon, Ann Arbor 48103
Ging, Rosalie J....Veterans Adm. Hosp., Ann Arbor 48105
Goldsmith, Robt. I..............216 Mich. Theatre Bldg., Ann Arbor 48106
Gonzalez-Videla, F. E. (A)............3501 Willis Rd., Ypsilanti 48197
Gosling, John R. G.....315 Corrie Rd., Ann Arbor 48105
Gottlieb, Joel D.......1800 Traver Rd., Ann Arbor 48105
Gotz, Alexander.....2201 Medford Rd., Ann Arbor 48104
Gould, Stuart M., Jr...........Mercywood Hosp., Box 65, Ann Arbor 48107
Grabb, William C. 325 Barton Shore Dr., Ann Arbor 48105
Gracie, Wm. A., Jr....2441 Shannondale, Ann Arbor 48104
Graves, Wm. H., III....2760 Provincial, Ann Arbor 48104
Gray, Jerry M.................St. Joseph Mercy Hosp., Ann Arbor 48104
Greene, James A., Jr.............251 Orchard Hills Dr., Ann Arbor 48104
Grillo, S. Phillip...........265 Main St., Belleville 48111
Gros, Gerard...........1025 Berkshire, Ann Arbor 48104
Gutierrez, Norma B...............Ypsilanti State Hosp., Ypsilanti 48197
Habel, Dan W. (M)..S 1708 Maple, Spokane, Wa. 99203
Hagerman, Geo. W...321 N. Ingalls St., Ann Arbor 48104
Haig, Owen G. (A)..2803 Towner Blvd., Ann Arbor 48104
Haight, Cameron......1313 E. Ann St., Ann Arbor 48104
Hammond, Walter W., Jr...........221 N. Sheldon Rd., Plymouth 48170
Handorf, H. H. (L)....455 Park Place, Northville 48167
Hankamp, Lamar J.....2119 Woodside, Ann Arbor 48104
Hannum, Marvin R...........54 W. Main, Milan 48160
Hanson, Frederick N...............34178 Spring Valley, Westland 48185
Harrell, E. R., Jr...............Univ. Med. Ctr., Rm. C, Ann Arbor 48104
Harris, Bradley M. (L)....27 S. Prospect, Ypsilanti 48197
Harris, Scott T.......44490 Clare Blvd., Plymouth 48170
Hartman, Robt. T............519 W. Main, Milan 48160
Hein, Gerhardt A. (A)...1121 Granger, Ann Arbor 48104
Henderson, John W....University Hosp., Ann Arbor 48104
Hendrix, Robt. C.....1139 Vesper Rd., Ann Arbor 48103
Henry, L. Dell (L)..706 W. Huron St., Ann Arbor 48103
Herbertson, F. James (A) 2381 Pinecrest, Ann Arbor 48104

Heston, Wm. M., III. .720 E. Catherine, Ann Arbor 48104
Hickok, David K. (M). .2526 Kalarama Rd., Portage 49081
Hicks, Samuel P.....1112 Meadowbrook, Ann Arbor 48103
Hildebrandt, H. Mark.....1130 Hill St., Ann Arbor 48104
Hinerman, Dorin L.....1313 E. Ann St., Ann Arbor 48104
Hing, Ng Harry....1323 Franklin Blvd., Ann Arbor 48103
Hiraga, Mikio H......1795 W. Stadium, Ann Arbor 48103
Hodges, Fred J. (L)....5 Highland Ln., Ann Arbor 48104
Holmes, Donald J.................505 Barton North Dr., Ann Arbor 48105
Holt, John F..........1313 E. Ann St., Ann Arbor 48104
Holtz, Fred............326 N. Ingalls, Ann Arbor 48104
Hoskins, Phillip A....824 Edgewood Pl., Ann Arbor 48103
House, Frederic B................1240 Crosby Crescent, Ann Arbor 48103
Howard, Stacy C. (R)..................1936 Whitehall, Winter Park, Fla. 32789
Howatt, William F. . University Hospital, Ann Arbor 48104
Hubbard, Wm. N., Jr..........Univ. of Mich. Med. Sch., Ann Arbor 48104
Huizenga, Philip B..............Box A, Ypsilanti 48197
Hulett, Ralph M.....2881 Provincial Dr., Ann Arbor 48104
Hull, Ralph F. (A). .Univ. Medical Ctr., Ann Arbor 48104
Hyman, Saml. J.......27342 Michigan Ave., Inkster 48141
Ideson, Robt. S., II....2200 Vinewood, Ann Arbor 48104
Jackson, Joseph E.....2220 Page Ave., Ann Arbor 48104
Jacob, Jos. S.....202 E. Washington St., Ann Arbor 48108
Jaffe, Burton (M). .1245 Creal Crescent, Ann Arbor 48103
Jeffries, Frank W. 425 E. Washington St., Ann Arbor 48108
Jender, Joseph G.....1302 W. Maple St., Plymouth 48170
Jimenez, B. (R).....215 A S. Main St., Ann Arbor 48108
Johnson, Paul S. (A). .3007 Geddes Ave., Ann Arbor 48104
Johnson, Robt. D.....3432 Woodlea Dr., Ann Arbor 48103
Johnston, Franklin D................University Hospital, Ann Arbor 48104
Joseph, Sydney. .2311 E. Stadium Blvd., Ann Arbor 48104
Judge, Richard D. . Univ. Medical Center, Ann Arbor 48104
Julian, Mark D...........740 S. Emerick, Ypsilanti 48197
Kahn, Edgar A.........500 Burson Pl., Ann Arbor 48104
Kambly, Arnold H., Jr. . 201 S. Main St., Ann Arbor 48108
Kaufer, Herbert.....Univ. Medical Ctr., Ann Arbor 48104
Kaump, Donald H.......P.O. Box 1047, Ann Arbor 48106
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Keaton, Alan L. (A)...2410 Walter Dr., Ann Arbor 48103
Kelley, Jack L. (M)............4513 1 O'Donnell Hts., Ft. Riley, Ks. 66442
Kelley, Paul A..........326 N. Ingalls, Ann Arbor 48104
Kem, David C. (M)....U. S. Army, Tripler Gen. Hosp., APO San Francisco, Ca. 96438
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Kerlikowske, A. C.....1313 E. Ann St., Ann Arbor 48104
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Kerry, Robert L.......2695 Appleway, Ann Arbor 48104
Kheder, Jamil.........44526 Clare Blvd., Plymouth 48170
Kimbrough, Wm. W. . 1231 Ferdon Rd., Ann Arbor 48104
Kittleson, Arthur C. 2111 Devonshire Rd., Ann Arbor 48104
Kivi, Louis P...........5950 W. Textile Rd., Saline 48176
Klein, Edward W...............St. Joseph Mercy Hosp., Ann Arbor 48104
Knoll, Leo A. (R).....2002 Scottwood, Ann Arbor 48104
Koepke, Geo. H.....University Hospital, Ann Arbor 48104
Komar, Norman N. (A)..........1605 Argyle Crescent, Ann Arbor 48103
Konzen, Jon L. (A).......7625 Second St., Dexter 48130
Kooi, Kenneth A.....2132 Needham Rd., Ann Arbor 48104
Kraft, Richard O. 2355 E. Stadium Blvd., Ann Arbor 48104
Krausse, Chas. F............116 Park St., Chelsea 48118
Krickstein, Herbert................564 Glen Arbor Ln., Grosse Pte. Woods 48236
Krigbaum, Edmund M...............3075 Overridge Dr., Ann Arbor 48104
Kumasaka, Glen H.....1411 Harbrooke, Ann Arbor 48103
Kwass, Stephen K. (M).............U. S. Naval Hosp., Bethesda, Maryland 20014
Lampe, Isadore........1313 E. Ann St., Ann Arbor 48104
Lane, Alexander Z....................5732 Pierson Rd., Fayetteville, N.Y. 13066
Lapides, Jack......University Hospital, Ann Arbor 48104
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Lease, Glenn O. . 3460 Cottontail Lane, Ann Arbor 48103
Lee, Fred..............1926 Day St., Ann Arbor 48104
Lindenauer, S. M. . 2711 Antietam Court, Ann Arbor 48105
Locken, Gail Ann. .8255 W. Huron River Dr., Dexter 48130
Lockett, Harold J.....319 Brookside Dr., Ann Arbor 48105
Lovell, Robert G......326 N. Ingalls St., Ann Arbor 48104
Lowrey, Geo. H.......University Hosp., Ann Arbor 48104
Lowry, Claud M.....1707 Shadford Rd., Ann Arbor 48104
Lucas, Alexander R.......951 E. Lafayette, Detroit 48207
Magee, Kenneth R.....1313 E. Ann St., Ann Arbor 48104
Magielski, John E...............2355 Londonderry Rd., Ann Arbor 48104
Magnuson, Harold J............1634 Univ. Medical Ctr., Ann Arbor 48104
Magoon, Duncan J. J.....225 E. Liberty, Ann Arbor 48108
Malcolm, Karl D.....311 N. Ingalls St., Ann Arbor 48104
Maley, John E.....5441 Walsh Rd., Whitmore Lake 48189
Margolis, Philip M...............725 City Center Bldg., Ann Arbor 48108
Markel, Sheldon F.............St. Joseph Mercy Hosp., Ann Arbor 48104
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Beard, James E..........23801 Fordson, Dearborn 48127
Beaudoin, Jacques.....17770 Mack, Grosse Pointe 48224
Beck, Stanley M., Jr....13118 Fort St., Wyandotte 48192
Becker, Abraham....3790 Woodward Ave., Detroit 48201
Beckett, Peter G. S....951 E. Lafayette St., Detroit 48207
Beckett, Victoria L. (A)...................1420 Anita, Grosse Pte. Woods 48236
Becklein, Clarence L.............14351 E. Warren Ave., Detroit 48215
Beckman, Hugh.........20001 Greenfield, Detroit 48235
Beckwith, Carl C.........15865 Wyoming, Detroit 48238
Bedell, Archie A.........15545 Mack Ave., Detroit 48224
Bedwell, Wm. L.........1211 Kales Bldg., Detroit 48226
Beebe, Willard E.......7636 Allen Rd., Allen Park 48101
Beekhuis, G. Jan......1326 St. Antoine St., Detroit 48226
Beeks, Billy................8824 Puritan, Detroit 48238
Beeuwkes, L. E.....13014 Mackenzie Ave., Detroit 48228
Behan, Robt. C........1 Woodward Ave., Detroit 48226
Beitman, Max R..........510 Kales Bldg., Detroit 48226
Beizai, Khosrow........22101 Moross Rd., Detroit 48236
Belamaric, Juan....1400 Chrysler Expwy., Detroit 48207
Belanger, W. Geo..........1041 Harvard, Detroit 48230
Belden, Darwin F...........2424 Puritan, Detroit 48238
Bell, J. Kenner (L)...660 Woodward Ave., Detroit 48226
Benavides, Claude................25750 W. Outer Dr., Lincoln Park 48146
Bende, Sandor F........15863 Garfield, Allen Park 48101
Beninson, Joseph........Henry Ford Hosp., Detroit 48202
Bennett, Germany E.......1446 E. Forest, Detroit 48207
Bennett, Harry B...........7015 Intervale, Detroit 48238
Bennett, H. Stanley....15101 Southfield, Allen Park 48101
Bennett, James A........6375 Pelham, Allen Park 48101
Bennett, Sanford A.............15301 W. Nine Mile Rd., Oak Park 48237
Bennish, Arvin..........17411 Greenfield, Detroit 48235
Bennish, E. Leo....14438 W. Six Mile Rd., Detroit 48240
Benson, Clifford D...1553 Woodward Ave., Detroit 48226
Benson, Davis A.........17563 Greenfield, Detroit 48235
Benson, Paul J......227 N. Sheldon Rd., Plymouth 48170
Benson, Virginia M. (L)....34636 Grove, Livonia 48154
Bentley, Robert H.......7220 Gratiot Ave., Detroit 48213
Bentley, Wm. G...........50 Westminster, Detroit 48202
Berdayes, Pedro P.............15345 Windmill Pte. Dr., Grosse Pte. 48236
Berger, Edwin L.....7301 Schaefer Rd., Dearborn 48126
Bergman, Gary D......7310 W. 7 Mile Rd., Detroit 48221
Bergman, Murray S....4400 Livernois Ave., Detroit 48210
Bergo, Howard L.....901 W. Grand Blvd., Detroit 48208

Berkas, Ernest M.........V.A. Hospital, Dearborn 48121
Berke, Joseph J.........3333 E. Jefferson, Detroit 48207
Berke, Sydney S.........3333 E. Jefferson, Detroit 48207
Berlin, Allen B.....17000 W. 8 Mile Rd., Southfield 48075
Berman, Martin B.......7411 Third Ave., Detroit 48202
Berman, Robt. H. (L)....2111 Woodward, Detroit 48201
Berman, Sidney L.........60 W. Hancock, Detroit 48201
Bernard, Henri....414 Dav. Whitney Bldg., Detroit 48226
Bernard, Walter G. (L)......910 Chalmer, Detroit 48215
Bernbaum, Bernard (L).........13345 W. Six Mile Rd., Detroit 48235
Bernstein, Saml. S...15901 W. 9 Mile Rd., Southfield 48075
Bernys, Conrad F.........3815 Pelham, Dearborn 48124
Berridge, William L...Chevrolet Motor Co., Livonia 48151
Berry, Jos. E.........19242 W. 7 Mile Rd., Detroit 48219
Bertram, Karl R.........461 Fisher Bldg., Detroit 48202
Besancon, John H........345 Lodge Drive, Detroit 48214
Best, Thos. H. E. (L)...........9221 E. Jefferson Ave., Detroit 48214
Betanzos, G...............22770 Kelly, E. Detroit 48021
Bethea, John H..............49000 W. Seven Mile Rd., Northville 48167
Bialik, Michael H...14853 Michigan Ave., Dearborn 48126
Bicknell, Frank B...938 Dav. Whitney Bldg., Detroit 48226
Bielawski, John G............825 David Whitney Bldg., Detroit 48226
Bihl, John H.......10531 Farmington Rd., Livonia 48150
Billingslea, Thos. H.......3790 Woodward, Detroit 48202
Bing, Richard J.....1400 Chrysler Expwy., Detroit 48207
Binns, Philip M..........573 Fisher Bldg., Detroit 48202
Birch, John R.....633 Dav. Whitney Bldg., Detroit 48226
Birk, Robert E...19787 Mack, Grosse Pointe Woods 48236
Birkam, Fred F.......7301 Schaefer Rd., Dearborn 48126
Birkhill, F. Ross...31 Shady Hollow Dr., Dearborn 48124
Birmingham, D. J......Wayne State Univ., Detroit 48207
Birmingham, John R...........14215 W. McNichols Rd. Detroit 48235
Birndorf, Leonard.......18317 John R St., Detroit 48203
Bissell, G. W............V.A. Hospital, Allen Park 48101
Bittker, Isadore I. (L).............3321 Rochester Rd., Royal Oak 48073
Bittrich, Norbert M...16001 9 Mile Rd., Southfield 48075
Black, Earl D.......20340 Harper, Harper Woods 48236
Black, Robert W...817 Dav. Whitney Bldg., Detroit 48226
Blain, Alexander, III....2201 E. Jefferson, Detroit 48207
Blain, James H., Jr.......935 Grand Marais, Detroit 48230
Blaine, Max............13700 Woodward, Detroit 48203
Blair, Wm. F..............81 E. Kirby St., Detroit 48202
Blanchard, Russell S.............12858 Woodward Ave., Detroit 48203
Blanks, Douglas H......12811 Northline, Southgate 48192
Blatt, Ronald W.................32226 Tall Timber Dr., Farmington 48024
Bleier, Alfred (A)..8801 Kingswood, #205, Detroit 48221
Blinkhorn, David H........25709 Salem, Roseville 48066
Block, Duane L.........3001 Miller Rd., Dearborn 48126
Block, Melvin A.....2799 W. Grand Blvd., Detroit 48202
Blodgett, James B.......76 W. Adams St., Detroit 48226
Blodgett, Wm. H.......74 W. Adams Ave., Detroit 48226
Blondy, Marshall J...19009 W. 7 Mile Rd., Detroit 48219
Bloom, Albert............6484 Chene St., Detroit 48211
Bloom, Arthur R. (L)........16500 N. Park Dr., #1406, Southfield 48075
Bloom, Victor...........951 E. Lafayette, Detroit 48207
Blosen, Rosemarie........2160 Gorno Ct., Trenton 48183
Bluhm, Gilbert B.......Henry Ford Hosp., Detroit 48202
Blum, George L....15901 W. 9 Mile Rd., Southfield 48075
Blumenthal, Frank S...........261 Brady, Detroit 48201
Blumenthal, Franz L. (L)...........2686 Heatherway, Ann Arbor 48104
Blumer, Abraham.22341 W. Eight Mile Rd., Detroit 48219
Boccaccio, John L..........11532 Morang, Detroit 48224
Boccia, James J.........15761 E. Warren, Detroit 48224
Boddie, Arthur W.........2737 Chene St., Detroit 48207
Bogucki, Chester J...............18620 Walmer Lane, Birmingham 48009
Bogue, Robt. E............15901 W. 9 Mile Rd., #604, Southfield 48075
Bogusz, Ladislaus (R).............29215 Maranya Rd., Homestead, Fl. 33030
Bohn, Z. Stephen...327 Professional Bldg., Detroit 48201
Bohne, A. Waite........Henry Ford Hosp., Detroit 48202
Boland, John R. (R)........Box 50, Grand Marais 49839
Boles, Murray...26381 Dundalk Lane, Farmington 48024
Bolstad, Donald S.......Henry Ford Hosp., Detroit 48202
Bolter, Sidney........18946 W. McNichols, Detroit 48219
Bolton, Norman.........19321 Greenfield, Detroit 48235
Bolton, Russell P., Jr....18530 Grand River, Detroit 48223
Boman, Robert H.............246 Eastland Prof. Bldg., Harper Woods 48236
Boneta, Otto F. W. (A)..................1151 Taylor, Herman Kiefer Hospital, Detroit 48202
Bonilla, Jaime........25447 Plymouth Rd., Detroit 48239
Bookstein, Abraham M..............1725 Pinecrest Dr., Ferndale 48220
Boone, Geo. F....................81 Woodland Shores, Grosse Pte. Shores 48236
Booth, Earnest.........Womans Hospital, Detroit 48201
Borchak, Robert G....17800 E. Eight Mile, Detroit 48236
Borden, Igor I........15361 Plymouth Rd., Detroit 48227
Borin, Maurice C.......18115 Fairfield St., Detroit 48221
Bornstein, Melvin.............17600 Northland Pk. Ct., Southfield 48075
Bornstein, Sidney.........16965 Hamilton, Detroit 48203
Borrego, Jose M.........1342 Whittier, Grosse Pte. 48236
Bott, Edmund T............1629 Ford, Wyandotte 48192
Botvinick, Isadore....13701 W. 7 Mile Rd., Detroit 48235
Boutrous, Thos. A.....15801 W. McNichols, Detroit 48235
Bower, Donald W......8863 Woodside, Grosse Ile 48138
Bowers, Leo J....11200 E. McNichols Rd., Detroit 48234
Bowersox, LeRoy W.................368 Franklin Ave., Redlands, Calif. 92373
Bowlby, James R...15420 Farmington Rd., Livonia 48154
Boyajian, Albert.......10963 Farmington, Livonia 48150
Boyce, Charles R.....3790 Woodward Ave., Detroit 48201
Boyd, Albert L...........9845 Reeck, Allen Park 48101
Boyd, John H. (L).....2615 W. Jefferson, Trenton 48183
Boyle, Eugene H..................572 Thorn Tree Rd., Grosse Pte. Woods 48236
Bracken, Andrew H. (L)..5460 Schaeffer, Dearborn 48126
Braden, Robt. G.........2300 Oak St., Wyandotte 48192
Bradfield, Horace F...3008 E. Grand Blvd., Detroit 48202
Bradfield, R. John........955 Fisher Bldg., Detroit 48202
Braley, Wm. N. (L)....12897 Woodward, Detroit 48203
Bramigk, Fritz W. (L).....178 Lakewood, Detroit 48215
Brand, Benj.....1201 David Whitney Bldg., Detroit 48226
Brane, Adolfo J..........Lafayette Clinic, Detroit 48207
Braun, Lionel...........18644 Muirland, Detroit 48221
Braun, Robert A......18610 Hartwell Ave., Detroit 48235
Braverman, Morris M...........1860 St. John Rd., 32-P, Seal Beach, Calif. 90740
Bredau, Frank N., Jr...24781 Five Mile Rd., Detroit 48239
Breiner, Sander J...7410 Franklin Rd., Birmingham 48010
Brekke, Viola G...369 Glendale St., Highland Park 48203
Bremer, John P.............17700 Mack, Detroit 48224
Bremer, Wm. M.........15641 E. Warren, Detroit 48224
Breneman, Gerald M............28300 Forest Brook Dr., Farmington 48024
Brennan, Michael J...............1168 Three Mile Dr., Grosse Pte. 48236
Brent, Morris S.......1330 Strathcona Dr., Detroit 48203
Brent, Robert L...1355 David Whitney Blg., Detroit 48226
Bresnahan, Boyd K...............17600 W. 8 Mile Rd., Southfield 48075
Brey, Norman W.............1900 Dav. Broderick Twr., Detroit 48226
Brickman, Murray.....24777 Greenfield, Southfield 48075
Briegel, Walter A. (R).............3233 N. E. 34th St., Ft. Lauderdale, Fl. 33308
Briggs, Wm. J...1900 Dav. Broderick Twr., Detroit 48226
Bringard, Elmer L.........18110 Fairfield, Detroit 48227
Brinkman, G. L...........Harper Hosp., Detroit 48201
Briski, Jacob E...1058 Blairmoor, Grosse Pte. Woods 48236
Brisson, John E..........17032 Fort St., Riverview 48192
Brisson, Jos. C. (R)..................23112 Westbury, St. Clair Shores 48080
Bristol, Wm. R............189 Claverly, Detroit 48236
Broadman, Sylvan A...25705 Middlebelt, Farmington 48024
Brock, Donald R.....36475 Five Mile Rd., Livonia 48154
Broderson, Harvey S. (R)...........10720 W. Jefferson, River Rouge 48218
Bromme, Wm. (L).......10 Peterboro St., Detroit 48201

Brooks, Eugene M............609 Northland Med. Bldg., Southfield 48075
Brooks, Nathan..............7401 3rd St., Detroit 48202
Brosius, Chas. O....16981 Farmington Rd., Livonia 48154
Brosius, Wm. L. (L)..............1823 Fair Oak Court, Rochester 48063
Brown, Andrew G.....20905 Greenfield, Southfield 48075
Brown, Audrey O. (L).............1795 Cedar Hill Dr., Birmingham 48010
Brown, Carlton F.....22335 Lagaronne, Southfield 48075
Brown, Chas. H..........2387 Fort St., Wyandotte 48192
Brown, Donald........Henry Ford Hosp., Detroit 48202
Brown, Eli M...13123 La Salle, Huntington Woods 48070
Brown, Frances (L)
Brown, Gordon T.......13000 Hayes Ave., Detroit 48205
Brown, James C...........5050 Joy Road, Detroit 48204
Brown, John R...1145 Dav. Whitney Bldg., Detroit 48226
Brown, Kenneth A.........17316 Livernois, Detroit 48221
Brown, Oscar A...1633 Dav. Whitney Bldg., Detroit 48226
Brown, Richard O...........1800 Tuxedo, Detroit 48206
Brown, Robt. A. (A)........1524 Vernon, Trenton 48183
Brown, Saml. M..........21821 Harding, Oak Park 48237
Brown, Saul....6890 White Pine Dr., Birmingham 48010
Brown, Stanley H. (L).........8544 W. McNichols Rd., Detroit 48221
Brown, Thos. A.....5430 W. Warren Ave., Detroit 48210
Brownell, H. H.....8222 Woodcrest Dr., Grosse Ile 48138
Brownell, Paul G...18916 Woodward Ave., Detroit 48203
Bruce,Thomas A...................2501 Wilshire Blvd., Oklahoma City, Ok. 73120
Bruder, Robt. C.....4520 Firestone Ave., Dearborn 48126
Bruer, Edgar S..........12170 Fort St., Wyandotte 48192
Bruer, Edwin L..........12170 Fort St., Wyandotte 48192
Brush, Brock E......2799 W. Grand Blvd., Detroit 48202
Bruton, Martin F........341 Massachusetts, Detroit 48203
Bryan, Donald I....15901 W. 9 Mile Rd., Southfield 48075
Buck, Raymond E.......1575 E. Lafayette, Detroit 48207
Buerki, Robin C.........Henry Ford Hosp., Detroit 48202
Buller, Harry L. (L)................167 E. Center St., Manchester, Ct. 06040
Burge, Robert H.........23843 Joy Rd., Dearborn 48127
Burke, Ralph M.....580 University Pl., Grosse Pte. 48236
Burnham, Thomas K.....Henry Ford Hosp., Detroit 48202
Burns, Robert E........Henry Ford Hosp., Detroit 48202
Burns, Robt. T.........11110 Morang Rd., Detroit 48224
Burnside, Howard B...................33 Oakland Park, Pleasant Ridge 48069
Burnstine, David.........18400 Schaefer, Detroit 48235
Burnstine, Julius Y. (L).....45 Owen Ave., Detroit 48202
Burnstine, Perry P....2329 W. Grand Blvd., Detroit 48208
Burr, Geo. C. (L)....1177 Devonshire, Grosse Pte. 48236
Burroughs, Roswell G.......1309 David Whitney Bldg., Detroit 48226
Burrows, Howard A. (L)........10423 W. Warren Ave., Dearborn 48126
Burrows, John H.......22101 Moross Rd., Detroit 48236
Burstein, Harry S....2950 W. Grand Blvd., Detroit 48202
Burstein, I. Marvin...2950 W. Grand Blvd., Detroit 48202
Burton, De Witt T. (L)....54 Arden Park, Detroit 48202
Burton, Irving F......................26912 York Rd., Huntington Woods 48070
Bush, Glendon J......18901 W. McNichols, Detroit 48219
Butler, James E......2177 W. Grand Blvd., Detroit 48208
Butler, John D.......2173 W. Grand Blvd., Detroit 48208
Butler, Lawrence H...14521 East 7 Mile Rd., Detroit 48205
Butler, Richard G.........1922 Monroe, Dearborn 48124
Butler, Volney N. (L)..28 W. Adams Ave., Detroit 48226
Buttrum, Edward J......14755 Fenkell St., Detroit 48227
Byers, Glen L. (A)..Detroit General Hosp., Detroit 48226
Cabral, Hector H...24860 River Heights, Southfield 48075
Cabrera, Enrique.....35337 W. Warren, Westland 48184
Cadger, Ralph E. (M)..........719 New Center Bldg., Detroit 48202
Cahalan, Jos. L..........15830 Fort St., Southgate 48192
Cahn, Bernard J. (A)..Detroit Gen. Hosp., Detroit 48226
Cain, Waldo L......8401 Woodward Ave., Detroit 48202
Caldwell, Geo. L. (L)...........12017 Joseph Campau, Detroit 48212
Caldwell, John R.....2799 W. Grand Blvd., Detroit 48202
Callaghan, Regis L......22146 Ford Rd., Dearborn 48128
Calmidis, Yani V........24800 Cromwell, Franklin 48025
Calwell, John G.....714 New Center Bldg., Detroit 48202
Cameron, Arthur H. (L)..............2853 Biddle Ave., Wyandotte 48192
Cameron, Duncan A.......2021 Monroe, Dearborn 48124
Campbell, Fredk. W., Jr.........648 N. Woodward Ave., Birmingham 48011
Campbell, Harvey E.....3 Robindale Ct., Dearborn 48124
Campbell, L. F...18101 Oakwood Blvd., Dearborn 48124
Campbell, Malcolm D. (L).........1520 N. Gulley Rd., Dearborn 48128
Campbell, Mary B. (L)................10454 Kingston, Huntington Woods 48070
Campbell, Robt. E......20901 Moross Rd., Detroit 48236
Campbell, Ruth B...........1536 David Whitney Bldg., Detroit, 48226
Campbell, Thelma M. 2355 Monroe Blvd., Dearborn 48124
Camps, Enrique........1966 Fairway, Birmingham 48009
Cancino-Samson, E. B...18700 Meyers Rd., Detroit 48235
Cantor, Herbert C................26831 N. Woodward, Huntington Woods 48070
Cantor, Meyer O..................4850 Charing Cross, Bloomfield Hills 48013
Cantow, Lawrence A.............19291 Warrington Dr., Detroit 48221
Cantrell, Mary E........Henry Ford Hosp., Detroit 48202
Capellari, Elmer E.......901 Mutual Bldg., Detroit 48226
Capetamakis, D. C.....27127 Southerland, Warren 48093
Capobres, David B.....3001 E. 7 Mile Rd., Detroit 48234
Caputo, Jos. M......2021 Monroe Blvd., Dearborn 48124
Caputo, Nancy T.....17712 Mack Ave., Grosse Pte. 48236
Capuzzi, Eugene T...................19061 La Crosse, Lathrup Village 48075
Caraway, James E. (R)..................R. 1, Box 503, Franklin, N.C. 28734
Carbone, Louis........14711 Gratiot Ave., Detroit 48205
Carbonell, Tomas.......353 Devonshire, Dearborn 48124
Carlisle, John C.......15101 Southfield, Allen Park 48101
Carlson, Harold W...18070 Wildemere Ave., Detroit 48221
Carman, Kenneth W...30928 Ford Rd., Garden City 48135
Carp, Jos..................8717 Van Dyke, Detroit 48213
Carpenter, C. J. (L)........P. O. Box 390, Wayne 48184
Carpenter, Wm. S.............18255 W. McNichols Rd., Detroit 48219
Carreon, Francisco P......6382 Trumbull, Detroit 48201
Carrick, Lee........18050 Mack Ave., Grosse Pte. 48236
Carroll, Elmer H. (L)...9920 Stoepel Ave., Detroit 48204
Carroll, Jerome G.....29588 Five Mile Rd., Livonia 48154
Carroll, Lona B. (L)..........938 David Whitney Bldg., Detroit 48226
Carson, Herman J........19149 7 Mile Rd., Detroit 48219
Carstens, Henry R. (L)..........6896 N. Clunbury Rd., Birmingham 48010
Carter, James A. U...19271 Strathcona Dr., Detroit 48203
Carter, John M. (L)............2860 N. E. 55th Court, Ft. Lauderdale, Fl. 33308
Carter, Leland F...........750 Middlesex, Detroit 48230
Casas, Miguel A.......9613 E. Outer Dr., Detroit 48213
Case, Hilda B............261 Mack Blvd., Detroit 48201
Cash, Morton B........St. Mary's Hospital, Livonia 48151
Cash, Ralph....15705 W. Ten Mile Rd., Southfield 48075
Cassel, Harry E........6742 Park Ave., Allen Park 48101
Castle, Maurice E.......20211 Greenfield, Detroit 48235
Catalano, Joseph V.....20905 Greenfield, Southfield 48075
Caughey, Andrew F., Jr...15256 Levan Rd., Livonia 48154
Caughey, Edgar H......11301 Whittier St., Detroit 48224
Caumartin, Fred E.......17184 Wildemere, Detroit 48221
Cellar, Frank A., Jr...............26789 Woodward Ave., Royal Oak 48072
Ceravolo, Albert J........468 Cadieux Rd., Detroit 48230
Ceresko, Anthony R.....9187 Mason Place, Detroit 48209
Cetnar, Eugene J.............4322 Bishop, Detroit 48224
Chalat, Ned I.......1553 Woodward Ave., Detroit 48226
Chall, Henry G. (L)...........2941 W. McNichols Rd., Detroit 48221
Chapin, Sidney E.......125 N. Military, Dearborn 48124
Chapman, Aaron L. (L)............406 W. Frisco Rd., Pensacola, Fl. 32507
Chapman, E. Forrest......36825 Bibbins, Romulus 48174
Chapman, Paul T.......1151 Taylor Ave., Detroit 48202
Chapman, Roland H...3790 Woodward Ave., Detroit 48201
Chapnick, Henry A..........19335 Prairie, Detroit 48221

Chapper, Barbara M........861 Monroe, Dearborn 48124
Charnas, Sidney..............15901 W. Nine Mile Rd., Southfield 48075
Charnley, Arnold D.....1678 Merriman Rd., Wayne 48184
Chase, Clyde H. (R)............2922 Dawes St. S.E., Grand Rapids 49508
Chason, Jacob L...........1401 Rivard St., Detroit 48207
Chavis, William M........13800 Livernois, Detroit 48238
Check, Frank E........76 W. Adams Ave., Detroit 48226
Chehab, Henri E....314 Lafayette Towers, Detroit 48207
Chen, Allen S. Y....11933 Belleville Rd., Belleville 48111
Chen, Calvin H............State Hosp., Northville 48167
Chen, Shek C...........1326 St. Antoine, Detroit 48226
Chen, You Chen.......Childrens Hospital, Detroit 48202
Chen, Vincent V...........1800 Tuxedo, Detroit 48206
Cherenzia, B. J...7437 Wellbourne Ct., Birmingham 48010
Chester, Alice....25085 Coolidge Hwy., Oak Park 48237
Chester, Wm. P...3800 Woodward, Rm. 802, Detroit 48201
Childs, George M.......1059 Fisher Bldg., Detroit 48202
Chipman, Willard A. (L)...........14613 Rutland Rd., Detroit 48227
Chipoco, Adolfo M.....25210 Grand River, Detroit 48240
Chodorkoff, Bernard....19435 Shrewsbury, Detroit 48221
Chown, Marion C..........2025 Ford, Wyandotte 48192
Christensen, R. C...................20861 Mack Ave., Grosse Pte. Woods 48236
Christopher, James G................20295 Douglas Ct., Birmingham 48010
Chrouch, Laurence A. (L)......Pleasant Hill, Tn. 38578
Church, Aloysius........19570 Bretton Dr., Detroit 48223
Cioffari, Mario S.............15924 W. Seven Mile Rd., Detroit 48235
Clapper, Muir...........1401 Rivard St., Detroit 48207
Clark, Arthur M.........401 River Lane, Dearborn 48124
Clark, Clarence M. (L)............2605 Holbrook Ave., Detroit 48212
Clark, Max D.....Wm. Beaumont Hosp., Royal Oak 48067
Clark, Wm. P..........1808 Baldwin, Ann Arbor 48104
Clarke, Chas. N..........21950 Greenfield, Detroit 48237
Clarke, Norman E. (L)...21950 Greenfield, Detroit 48237
Clarke, Norman E., Jr.....21950 Greenfield, Detroit 48237
Clarke, Robt. B........76 W. Adams Ave., Detroit 48226
Clemens, Raymond R.........23843 Joy, Dearborn 48127
Clermont, Volna............5050 Joy Rd., Detroit 48204
Clifford, John E..............18348 Mack, Detroit 48236
Climie, Andrew R. W.....Harper Hospital, Detroit 48201
Cline, Richard S...401 N. Oneida St., Appleton, Wis 54911
Clune, John P. (M)...........226 Eastland Prof. Bldg., Harper Woods 48236
Coates, E. Osborne, Jr...Henry Ford Hosp., Detroit 48202
Cobane, John H. (L)...10 Peterboro Ave., Detroit 48201
Cochrane, Edgar G...503 Med. Arts Bldg., Detroit 48203
Cocorelis, S. G. (A)..Jack Garris, Municipal Court Bldg., Ann Arbor 48104
Cohen, David M. (A).............Wayne State Univ., 1400 Chrysler Expwy., Detroit 48207
Cohen, Herbert H....12700 W. 7 Mile Rd., Detroit 48235
Cohn, Danl. E.............409 Fox Bldg., Detroit 48201
Cohn, S. Leonard................28505 Southfield Rd., Lathrup Village 48075
Cohoe, Don A. (L)..18916 Woodward Ave., Detroit 48203
Cole, James E. (L).....344 Glendale Ave., Detroit 48203
Cole, Wyman C. C. (L)..........1116 Leisure Lane, #3, Walnut Creek, Ca. 94529
Cole, Wyman C. C., Jr.................23843 Joy Road, Dearborn Hgts. 48127
Coleman, Margarete W. (L).........4214 N. Woodward, Royal Oak 48072
Coleman, Wm. G...20526 Grand River Ave., Detroit 48219
Coles, Thomas B., Jr.......Grace Hospital, Detroit 48201
Collings, M. Raymond (A)........9201 W. Outer Drive, Detroit 48219
Collins, James E...13103 W. Chicago Blvd., Detroit 48228
Collins, James W.........13800 Livernois, Detroit 48238
Colvin, Leslie T. (R)...........15015 Glastonbury Rd., Detroit 48223
Colyer, Raymond G. (R)..284 Pilgrim, Birmingham 48009
Combs, Julius V............2424 Puritan, Detroit 48238
Comstock, Lawrence A.....3700 West Rd., Trenton 48183
Conklin, Emma J....Wayne Co. Gen. Hosp., Eloise 48132
Conley, Lowry C. M. (L)..99 Tuxedo Ave., Detroit 48203
Connelly, Richard C...............1360 Three Mile Dr., Grosse Pte. 48236
Connolly, Paul J......3800 Woodward Ave., Detroit 48201
Connor, Phyllis M.....Henry Ford Hosp., Detroit 48202
Connors, John J....25657 Southfield Rd., Southfield 48075
Conway, Gerald F............938 David Whitney Bldg., Detroit 48226
Cook, Carla A..........Henry Ford Hosp., Detroit 48202
Cook, James A........2246 20th Street, Wyandotte 48192
Cook, James C............3825 Brush St., Detroit 48201
Cookinham, Frank......999 S. Highland, Dearborn 48124
Cooksey, Warren B. (L)..........3535 W. 13 Mile Rd., Royal Oak 48072
Cooper, James B.....18150 Mack Ave., Grosse Pte. 48236
Cooper, Ralph R...1515 Dav. Whitney Bldg., Detroit 48226
Cooper, Richard F...............18100 Shadbrook Dr., Northville 48167
Cooper, Thomas M...8445 E. Jefferson Ave., Detroit 48214
Corbeille, Catherine (L)..........3011 W. Grand Blvd., Detroit 48202
Corbett, David P.........Harper Hospital, Detroit 48201
Cortez, Joseph A.....19350 W. McNichols, Detroit 48219
Costello, Russell T...3001 W. Grand Blvd., Detroit 48202
Costello, Stephen D.....9435 Island Dr., Grosse Ile 48138
Cotant, John F.............15901 W. 9 Mile Rd., #420, Southfield 48075
Coto, Moises G.............VA Hosp., Allen Park 48101
Cotton, Schuyler O. (R)......2332 Carson, Detroit 48209
Courville, Chas. J.............703 Northland Med. Bld., Southfield 48075
Cowan, Wilfrid (L)..............416 North Shore Dr., St. Clair Shores 48080
Cowen, Leon B. (L)..............10225 N. Balboa Dr., Sun City, Az. 85351
Cowen, Robt. L. (L)........91 E. Kirby, Detroit 48202
Cox, Frank, Jr..........Henry Ford Hosp., Detroit 48202
Coyle, James E......17770 Mack Ave., Grosse Pte. 48224
Craig, Roy D........3790 Woodward Ave., Detroit 48201
Craig, Roy E...74 Fontana Lane, Grosse Pte. Shores 48236
Crawley, Eugene H....................885 Bloomcrest, Bloomfield Hills 48013
Crews, Thos. H. (L)..3011 W. Grand Blvd., Detroit 48202
Crippen, Edward F............316 City County Bldg., Detroit 48226
Crockett, E. E. J............1327 Nicolet, Detroit 48207
Croll, Leo J.........12703 W. 7 Mile Rd., Detroit 48235
Croll, Maurice...12703 W. Seven Mile Rd., Detroit 48235
Crook, Chas. L.....60 Colorado St., Highland Park 48203
Cross, Harold E...68 N. Deepland Rd., Grosse Pte. 48236
Crossen, Robert J.....933 David Wh. Bldg., Detroit 48226
Croushore, James E. (L)......561 N.E. Golden Harbour, Boca Raton, Fl. 33432
Cruz, Victor M.............15901 W. 9 Mile Rd., #303, Southfield 48075
Cserhalmi, Maria V......1302 Beaconsfield, Detroit 48230
Cubberley, Robt. B.......1800 Tuxedo St., Detroit 48206
Cullis, Frank............261 Mack Blvd., Detroit 48201
Curhan, Robert P.......18709 Meyers Rd., Detroit 48235
Curtis, Frank E. (L)....273 Kenwood Ct., Detroit 48236
Curtiss, Wm. P...22631 Mack Ave., St. Clair Shores 48080
Cusick, Paul L.....15901 W. 9 Mile Rd., Southfield 48075
Cyrowski, Gerald A...........15901 W. Nine Mile Rd., Southfield 48075
Daignault, F. M.......20905 Greenfield, Southfield 48075
Daitch, Harold J...22341 W. Eight Mile Rd., Detroit 48219
Daitch, Martin H....15244 Middlebelt Rd., Livonia 48154
Dale, Esther H. (L)......1401 Rivard St., Detroit 48207
Dale, Mark............3702 E. 8 Mile Rd., Detroit 48234
Dal Santo, G.............1401 Rivard St., Detroit 48207
Daly, Eugene T............24781 Fenkell, Detroit 48223
Danforth, James C., Jr...............20175 Mack Ave., Grosse Pte. Woods 48236
Danforth, Robt. D..................20175 Mack Ave., Grosse Pte. Woods 48236
Danielski, John J..........35478 Parkdale, Livonia 48150
Danto, Bruce L..........466 Fisher Bldg., Detroit 48202
Danz, George W...........1539 Ford, Wyandotte 48192
Daoust, Patrick H.......15520 Garfield, Allen Park 48101
Darling, Chas. E.........673 Fisher Bldg., Detroit 48202
Davidson, Harry O...2799 W. Grand Blvd., Detroit 48202
Davies, Windsor S.......28 W. Adams Ave., Detroit 48226

Davis, Herbert A......9901 Melbourne, Allen Park 48101
Davis, Jerome D.....19075 Middlebelt Rd., Livonia 48152
Dawson, W. A. (R)..........188 Lake Silver Dr. N.W., Winter Haven, Fl. 33880
Day, A. Jackson............3800 Woodward Ave., #406, Detroit 48201
Day, Francis T.............18540 Mack, Detroit 48236
Day, Jay C..............1016 Prof. Plaza, Detroit 48201
Day, Jorge H. 1787 Newcastle, Grosse Pointe Woods 48236
Day, Ruth S.........3790 Woodward Ave., Detroit 48201
Dayioglu, Vehbi...27560 Cherry Hill, Garden City 48135
de Aenlle, Eliodoro........29022 Merrick, Warren 48092
Dean, Carleton R. (M)..............Region II, HEW, 26 Federal Plaza, New York, N. Y. 10007
Dean, George A.........19309 Greenfield, Detroit 48235
De Busk, Roger W........4160 John R St., Detroit 48201
Deering, Robt. J.....1359 Champaign, Lincoln Park 48146
DeFever, Cyril R.......19787 Mack Ave., Detroit 48236
De Groat, Albert F. (L)..1151 Taylor Ave., Detroit 48202
De Jongh, Edwin....Gen. Motors Building, Detroit 48202
Delaini, Stella M.....3011 W. Grand Blvd., Detroit 48202
De Lawrence, Betty J.............21576 Michigan Ave., Dearborn 48124
De Lawrence, Thomas............21576 Michigan Ave., Dearborn 48124
Del Giorno, Thos. E. (A)................Mecosta 49332
Delgiudice, P. A...........Grace Hospital, Detroit 48201
Del Valle, Francisco....3729 Fort St., Lincoln Park 48146
Del Valle, Mario..........19936 Packard, Detroit 48234
Denson, Andrew L. (A)..2224 Hazlewood, Detroit 48206
Deresz, Alphonse R.....4204 E. Outer Dr., Detroit 48234
Derleth, Paul E.....563 W. Oakridge Ave., Ferndale 48220
Derrick, C. F.......3677 Fort Street, Lincoln Park 48146
Deryke, Gilbert R.......35006 Wood Drive, Livonia 48154
De Smyter, Geo. C.......15527 E. Warren, Detroit 48224
DeSpelder, Ray E.............610 Blaine, Detroit 48202
DesRoberts, Yvon J.....18430 Mack Ave., Detroit 48236
Deuby, Owen J...15121 W. Seven Mile Rd., Detroit 48235
Devine, Herbert W.......22101 Moross Rd., Detroit 48236
Diakow, Lilian M.....1539 N. Line Rd., Wyandotte 48192
Dickenman, Robert C...........Detroit Memorial Hosp., Detroit 48226
Dicksheet, Sharad K.....23151 Van Dyke, Warren 48089
Dickson, Basil R......337 W. Grand Blvd., Detroit 48216
Dickson, Elias L., Jr.......17320 Livernois, Detroit 48221
Dickson, Leon A........5535 W. Chicago, Detroit 48204
Dickson, Mary D.....................18424 Mack Ave., Grosse Pte. Farms 48236
Diebel, Nelson W........660 Cadieux Rd., Detroit 48230
Diekman, Fred C. 31815 Southfield Rd., Birmingham 48009
Dietze, Margaret R.........861 Monroe, Dearborn 48124
Dietzel, Hugo O. (R)................844 Hemlock Dr., San Carlos, Ca. 94070
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Dill, Hugh L. (L)..16114 E. Warren Ave., Detroit 48224
Dill, J. Lewis................7387 Deep Run, Apt. 312, Birmingham 48010
Dillon, Thomas K. (A).....22250 Puritan, Detroit 48223
Di Loreto, Panfilo C.....285 Vincennes Pl., Detroit 48236
Di Maso, Gennaro J......20963 Kelly, East Detroit 48021
Dimond, Geo. E.........18401 Bretton Dr., Detroit 48223
Dipiero, Raniero............1800 Tuxedo, Detroit 48206
Dittmer, Edwin F.....18342 Mack Avenue, Detroit 48236
Dixon, Fredk. W.........245 S. Martha, Dearborn 48124
Dixon, Ray S. (L)........5001 Van Dyke, Detroit 48213
Doane, Clifford L...15041 East Seven Mile, Detroit 48205
Dodds, John C. (L)..18520 W. 7 Mile Rd., Detroit 48219
Dodenhoff, Chas. F.......18031 Kelly Rd., Detroit 48224
Dodrill, Forest D...Woodberry Dr., Bloomfield Hills 48013
Doering, Wendell R...17555 James Couzens, Detroit 48235
Doig, Victor F...............19676 Dale, Detroit 48219
Dolan, Edward A............1960 Hammond Lake Dr., Pontiac 48053
Dolega, Stanley F...15640 E. Warren Ave., Detroit 48224
Dolgoff, Sidney....15600 Michigan Ave., Dearborn 48126
Dolin, Simon..........28500 Bell Rd., Southfield 48075
Domjancic, John T..................Outer Drive Hosp., Lincoln Park 48146
Domzalski, Henry M...15252 Gratiot Ave., Detroit 48205
Donath, Rolf W.....719 New Center Bldg., Detroit 48202
Donovan, Eugene T. 13349 Michigan Ave., Dearborn 48126
Donovan, Richard S...17555 James Couzens, Detroit 48235
Dopico, Alfredo J. 6221 Merriman Rd., Garden City 48135
Doran, John H........15101 Plymouth Rd., Detroit 48227
Dorman, Jack..21701 W. 11 Mile Road, Southfield 48075
Dorostkar, M. G.........45101 Harmony, Belleville 48111
Dorsey, Edward C.......9000 E. Jefferson, Detroit 48214
Dorsey, John M.....65 Moss Avenue, Highland Park 48203
Doshi, Bhogilal C...........10448 Lincoln, Taylor 48180
Doty, Chester A. (L)...........135 E. Maryland Ave., Phoenix, Az. 85012
Doub, Howard P. (L)...........2799 W. Grand Blvd., Detroit 48202
Dougherty, Edw. A., Jr.........18241 W. McNichols Rd., Detroit 48219
Douglas, Clair L. (L).........1201 Richmond St., #807, London, Ont., Canada
Douglass, Robt. C.............23023 Orchard Lake Rd., Farmington 48024
Dovitz, Benj. W.....16820 Greenfield Ave., Detroit 48235
Downer, Ira G. (L)..8445 E. Jefferson Ave., Detroit 48214
Downes, Geo. O...........15062 Houston, Detroit 48205
Drake, Ellet H.........Henry Ford Hosp., Detroit 48202
Drapiza, Ruth L.....22231 W. Outer Dr., Dearborn 48124
Draves, Edward F..........19647 Joy Rd., Detroit 48228
Drazek, Jos. A..........14001 Greenfield, Detroit 48227
Dreyer, Joel......15800 W. McNichols Rd., Detroit 48235
Drouin, Michel (A).......V.A. Hospital, Dearborn 48121
Drozdowska, Z. J. F.......2357 Golfview Dr., Troy 48084
Drukker, Bruce H...Henry Ford Hospital, Detroit 48202
Drumm, John K.......1420 St. Antoine St., Detroit 48226
D'Sena, Dorothy........33000 Palmer Rd., Wayne 48184
Dubin, Joseph J...2037 Medford Road, Ann Arbor 48104
Dubpernell, Martin S. (L)..4019 Gilbert St., Detroit 48210
Dubpernell, Robt. O....18595 Grand River, Detroit 48223
Dudek, John J.........19244 Grand River, Detroit 48223
Dumke, Paul R......2799 W. Grand Blvd., Detroit 48202
Duncan, James R...........5050 Joy Rd., Detroit 48204
Dunlap, Henry A...7815 Jefferson Ave. E., Detroit 48214
Dunn, Cornelius E. (L)..17230 Mack Ave., Detroit 48236
Dunn, John S. (A)....................368 Ridgemont, Grosse Pte. Farms 48236
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Durham, Everett W..............23100 Cherry Hill Rd., Dearborn 48124
Durham, Robt. (L).....Henry Ford Hosp., Detroit 48202
Dutcher, Dwight J..........711 S. Oxford, Detroit 48236
Duwe, Frank A.......25321 Five Mile Rd., Detroit 48239
Dwaihy, Paul J. (A).....14530 E. Warren, Detroit 48215
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Dyer, H. Lorne.........115 E. Dunlap, Northville 48167
Dykema, Rosemary M.....18424 Mack Ave., Detroit 48236
Dziuba, John F.....18901 W. Warren Ave., Detroit 48228
Dzul, Paul...........17800 E. 8 Mile Rd., Detroit 48236
Eades, Chas. C. (R)..649 Rivard Blvd., Grosse Pte. 48236
Easterly, Robt. L.....1404 Ford Avenue, Wyandotte 48192
Echt, Raymond J.........V.A. Hospital, Dearborn 48121
Eckhous, Arthur W.......1015 Kales Bldg., Detroit 48226
Economy, Donald E.....18 W. Lane Ct., Dearborn 48124
Eder, Saml. J. (L)......19541 Cranbrook, Detroit 48221
Edgar, Irving I...1036 Dav. Whitney Bldg., Detroit 48226
Edmonds, Wm. N. (L)...........18525 Merriman Rd., Livonia 48152
Edmondson, Robt. B.....18501 Mack Ave., Detroit 48236
Edwards, C. Rupert L...........Detroit Receiving Hosp., Detroit 48226
Edwards, James G...17751 E. Warren Ave., Detroit 48224
Egan, Charles F.................Wyandotte Gen. Hosp., Wyandotte 48192
Eisenbrey, A. B.........1026 Fisher Bldg., Detroit 48202
Eisenstein, B.............459 Fisher Bldg., Detroit 48202
Eldredge, Edward F...18540 Mack Ave., Grosse Pte. 48236
Elie, Jean C......938 Dav. Whitney Bldg., Detroit 48226
Elliott, Jos. P., Jr........Henry Ford Hosp., Detroit 48202
Ellis, Frank R..........800 S. Lafayette, Dearborn 48124
Ellison, Leonard E...3800 Woodward Ave., Detroit 48201
Elman, Meyer J..........108 W. Hancock, Detroit 48201
Elson, Abraham L........Lafayette Clinic, Detroit 48207
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Enfroy, Henri L...7421 W. Seven Mile Rd., Detroit 48221
Engel, Earl H...2336 Van Alstyne Blvd., Wyandotte 48192
Engstrom, Fredk. W.......2021 Monroe, Dearborn 48124
Engstrom, Ruby M.....1777 Culver Ave., Dearborn 48124
Eno, Laurel S.......212 Eastland Pr. Bldg., Detroit 48236
Ensign, Dwight C......Henry Ford Hosp., Detroit 48202
Eppler, William R...........20160 Mack, Detroit 48236
Epstein, Burton S........18215 Greenfield, Detroit 48235
Erickson, Eldon W................25750 W. Outer Dr., Lincoln Park 48146
Erickson, Miles A......1932 Ford Ave., Wyandotte 48192
Ericsson, Arthur D........Harper Hospital, Detroit 48201
Ericsson, Judith A...719 New Center Bldg., Detroit 48202
Erman, Jos. M........19530 Stratford Rd., Detroit 48221
Ermete, Sait D.....32633 Cherry Hill, Garden City 48135
Ernst, Reginald H...........5050 Joy Rd., Detroit 48204
Eschbach, Jos. W.....935 S. Military St., Dearborn 48124
Eskandari, Freydoon.3800 Woodward Ave., Detroit 48202
Eurs, Frank J.......................20485 Mack Ave., Grosse Pte. Woods 48236
Evans, Gomer P., Jr...1553 Woodward Ave., Detroit 48226
Evans, Jos. M..............16431 Harper, Detroit 48224
Evans, Tommy N.......18630 Fairway Dr., Detroit 48221
Ewing, Chas. H.........17120 E. Warren, Detroit 48224
Eyler, Wm. R.......2799 W. Grand Blvd., Detroit 48202
Eyres, Alfred E.......17800 E. Eight Mile, Detroit 48236
Fachnie, Harold L....17401 Greenfield Rd., Detroit 48235
Faello, Sebastian J...16840 E. Warren Ave., Detroit 48224
Fagan, James P..........987 E. Jefferson, Detroit 48207
Fagin, Irving D......18254 Livernois Ave., Detroit 48221
Fahim, Ramfis B.......14634 E. 7 Mile Rd., Detroit 48205
Falick, Mordecai L..........2257 Golfview, Troy 48084
Falk, Ira E...........17411 Cherrylawn, Detroit 48221
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Fanego, Luis R...........4496 Larme, Allen Park 48101
Farbman, Aaron A........14515 Kercheval, Detroit 48215
Farina, Angel M...........23550 Joy Rd., Detroit 48239
Farjardo, A. C..........Oakwood Hosp., Dearborn 48124
Farnam, Larry M., Jr........6200 Cadieux, Detroit 48224
Faunce, Sherman P......1824 Seminole St., Detroit 48214
Fea, John F......Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Maureen S...........Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Theodore M..........Mt. Carmel Mercy Hosp., Detroit 48235
Feld, David.....15101 W. McNichols Rd., Detroit 48235
Feldkamp, Lee E..........360 N. Main, Plymouth 48170
Feldman, Irwin..........37380 Glenwood, Wayne 48184
Feldman, Nathanial L. (A)..........9420 S.W. 91st St. Miami, Fl. 33156
Feldman, Paul H.........16800 Greenfield, Detroit 48235
Feldstein, Martin Z...........13345 W. McNichols Rd., Detroit 48235
Fellner, Wm. A...3 202 Gen. Motors Bldg., Detroit 48202
Fellows, William R.........3815 Pelham, Dearborn 48124
Fenech, Harold B. (L)...3790 Woodward, Detroit 48201
Fenner, Wm. G.......12454 E. Outer Dr., Detroit 48224
Fennessey, John F.........512 Rivard, Grosse Pte. 48236
Fenton, James L. (M)..........1615 Birmingham Blvd., Birmingham 48009
Fenton, Meryl M...15901 W. 9 Mile Rd., Southfield 48075
Fenton, Russell F. (L).........15125 Grand River Ave., Detroit 48227
Fenton, Stanley C. (L)...15618 E. Warren, Detroit 48224
Fenton, Stuart V.............17600 Northland Park Ct., Southfield 48075
Fentress, Vance....308 Professional Plaza, Detroit 48201
Feringa, Philip J........20901 Moross Rd., Detroit 48236
Fernandez-Pena, C. E. (A)....Grace Hosp., Detroit 48201
Fernando, Oscar (A)......Grace Hospital, Detroit 48201
Ferrara, Richard J...................20045 Mack Ave., Grosse Pte. Woods 48236
Ferrara, Virginia M......18422 Woodward, Detroit 48203
Ferrari, Fulvio M...Northville St. Hosp., Northville 48167
Ferris, George N.........20001 Greenfield, Detroit 48235
Ferszt, Marion S.........15369 Grandville, Detroit 48223
Figiel, Leo S.............1500 Balmoral, Detroit 48203
Figiel, Steven J...........4160 John R St., Detroit 48201
Filkin, Lawrence E.......621 Fairbrook, Northville 48167
Fill, Leon..........2310 Cass, Exec. Suite, Detroit 48201
Finch, Alvis D...18000 Jas. Couzens Hwy., Detroit 48235
Finch, F. Sinclair........894 N. Renaud, Detroit 48236
Finck, Jerome H.........25841 Plymouth, Detroit 48239
Fine, Edward.....15901 W. 9 Mile Rd., Southfield 48075
Fine, Gerald...........Henry Ford Hosp., Detroit 48202
Fink, Saml...............10161 Burton, Oak Park 48237
Finkelstein, I. S.........17508 Dorset, Southfield 48075
Finkelstein, M. B.........18254 Livernois, Detroit 48221
Firestone, N.S. (M)............6672 Cottonwood Knoll, Birmingham 48010
Firnschild, Paul G......8 Shady Hollow, Dearborn 48124
Fischer, Arthur J.....36016 Five Mile Rd., Livonia 48154
Fischer, Fredk. J.........654 Fisher Bldg., Detroit 48202
Fishbein, Herbert L...987 E. Jefferson Ave., Detroit 48207
Fisher, Geo. S....1709 Dav. Whitney Bldg., Detroit 48226
Fisher, James M.....176 Merriweather, Grosse Pte. 48236
Fitzgerald, C. H...Wayne Co. Gen. Hospital, Eloise 48132
Fitzgerald, James M...15801 W. McNichols, Detroit 48235
Fitzpatrick, F. W..........17187 Schaefer, Detroit 48235
Flaherty, Henry J.............19600 W. McNichols Rd., Detroit 48219
Flaherty, Norman W..............24315 Fairmont Dr., Dearborn 48124
Flake, Thomas M.....13800 Livernois Ave., Detroit 48238
Flora, Wm. R.....17800 E. Eight Mile Rd., Detroit 48236
Flower, James A. (R)................1500 Via Soledad, Palm Springs, Ca. 92262
Floyd, William S.................28505 Southfield Rd., Lathrup Village 48075
Fly, Marie N.........Oakwood Hospital, Dearborn 48124
Fogt, Robt. G.......316 Neff Road, Grosse Pointe 48230
Foley, Hugh S. (L).....1013 Haugh St., Dearborn 48124
Foote, John A....1336 Southfield Rd., Lincoln Park 48146
Ford, Geo. A. (L).....28 W. Adams Ave., Detroit 48226
Fordell, Frank S.....22159 W. Outer Dr., Dearborn 48124
Forgrave, Edward G....18520 Grand River, Detroit 48219
Forrer, Gordon R...20141 James Couzens, Detroit 48235
Fosnaugh, Robert P...23185 Timberline, Southfield 48075
Foster, E. Bruce....20905 Greenfield Rd., Southfield 48075
Foster, Owen C. (L)............1553 Woodward Ave., Detroit 48226
Foster, Wallace M...............13700 Woodward Ave., Highland Park 48203
Fountain, Charles W..2012 Monroe Blvd., Dearborn 48124
Fowler, Melvin E......247 E. Warren St., Detroit 48201
Fox, Thomas A., Jr......Henry Ford Hosp., Detroit 48202
Fraiberg, Paul L.......1454 Strathcona Dr., Detroit 48203
Frame, Boy......543 Lakepointe, Grosse Pte. Park 48230
France, Chas. J...17800 E. Eight Mile Rd., Detroit 48236
Frankel, Maurice A...............17000 W. Eight Mile, Southfield 48075
Franklin, John E.............4075 Ink Rd., Inkster 48141
Franzen, Nils A.......15360 Oakfield Ave., Detroit 48227
Frederickson, Geo. C.........7430 Second, Detroit 48202
Free, Harry W.......14300 W. McNichols, Detroit 48235
Freedman, John (R)....4853 Second Blvd., Detroit 48201
Freeman, Donald K.......881 Chalmers St., Detroit 48215
Freeman, Mable (L)..........1316 Dav. Broderick Twr., Detroit 48226
Freeman, Michael W....1810 Wellesley Dr., Detroit 48203
Freeman, Richard F...........525 Visger, Ecorse 48229
Freeman, Wilmer.....940 East 7 Mile Rd., Detroit 48203
Freid, Samuel.............17537 Parkside, Detroit 48221
Freier, Andrew A....18597 W. Ten Mile, Southfield 48075
Freier, Morton L......13051 Puritan Ave., Detroit 48227
Freitas, Eugene L.......St. Johns Hospital, Detroit 48236
Fremont, J. Courtney (A)..............55 Hall Place, Grosse Pte. Farms 48236
Friedlaender, Alex S...........10300 W. Seven Mile Rd., Detroit 48221
Friedlaender, Sidney..........10300 W. Seven Mile Rd., Detroit 48221
Friedlander, Joseph (A).......3776 Leslie, Detroit 48238
Friedman, David.........1333 Strathcona, Detroit 48203
Friedman, Hyman.....6742 Park Ave., Allen Park 48101

Friedman, Isidor H. (L)..3773 Second Ave., Detroit 48201
Friedman, Seymour......5132 Allen Rd., Allen Park 48101
Fromm, Stefan H...1400 Chrysler Freeway, Detroit 48207
Frost, Harold M.........Henry Ford Hosp., Detroit 48202
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Fryfogle, James D.......15901 W. Nine Mile Rd., #715, Southfield 48075
Fulgenzi, William R......1210 Kales Bldg., Detroit 48226
Fuller, Hugh M...404 David Whitney Bldg., Detroit 48226
Fulton, Wm. J. (R)..Wye Ferry, Queenstown, Md. 21658
Gagliardi, Carl A.......3516 Fort St., Lincoln Park 48146
Gajewski, John E.....Parke, Davis and Co., Detroit 48232
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Galantowicz, H. C. (L)..7433 Mich. Ave., Detroit 48210
Galantowicz, Thos. H.....23601 Ford Rd., Dearborn 48128
Galdonyi, Laslo (L)..........2311 Dav. Broderick Twr., Detroit 48226
Galerneau, Darrel B. (L)..........144 S. Wilson Blvd., Mt. Clemens 48043
Gall, Henry........10531 Farmington Rd., Livonia 48150
Gallagher, Edw. W. (A)..18040 Fenmore, Detroit 48235
Gallagher, James P...14801 Southfield, Allen Park 48101
Gallant, Vincent J.........1414 Wellesley, Detroit 48203
Gallucci, Richard P.....23100 Cherryhill, Dearborn 48124
Galvin, John P...19959 Vernier Rd., Harper Woods 48236
Ganos, Thos...........6742 Park Ave., Allen Park 48101
Gans, Robert I....7310 W. Seven Mile Rd., Detroit 48221
Ganschow, John H.....1840 Holbrook Ave., Detroit 48212
Garcia, Remigio........Henry Ford Hosp., Detroit 48202
Gardner, Lawrence W...6071 W. Outer Dr., Detroit 48235
Gardner, Max L.....19557 Mack Ave., Grosse Pte. 48236
Gariepy, Louis B...400 Southfield Rd., Birmingham 48009
Gariepy, Louis J. (L)...............400 Southfield Rd., Birmingham 48009
Gass, H. Harvey.........529 Fisher Bldg., Detroit 48202
Gaston, Herbert B.............7501 W. Morrow Circle, Dearborn 48126
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George, Alma R.............2424 Puritan, Detroit 48238
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Gibson, Wm.........3790 Woodward Ave., Detroit 48202
Giese, Fred W..........18526 Schoolcraft, Detroit 48223
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Gigliotti, David......16001 9 Mile Rd., Southfield 48075
Gilbert, Harold R........13146 Phelps, Wyandotte 48192
Giles, Conrad L...............407 Northland Med. Bldg., Southfield 48075
Gillespie, Stephen M...23100 Cherry Hill, Dearborn 48124
Gilpin, Watson A...1539 Lockridge, Bloomfield Hills 48013
Gilreath, James L...........1800 Tuxedo, Detroit 48206
Gilroy, John.............Harper Hospital, Detroit 48201
Gimbel, Nicholas S..........1800 Tuxedo, Detroit 48206
Ginsberg, Harold I...15344 McNichols Rd., Detroit 48235
Girnius, Birute............15439 Harper, Detroit 48224
Gitlin, Chas. (L)......2424 Oakman Blvd., Detroit 48238
Gittins, Perry C. (L)..............20905 Greenfield Rd., Southfield 48075
Givens, Donovan H., Jr.......726 Lathrup, Detroit 48202
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Glasgow, Gordon K. (R)............339 Chalfonte Ave., Grosse Pte. Farms 48236
Glazer, Walter S. (A)............1490 Charrington Rd., Birmingham 48010
Glement, Raymond D. (L).........16126 Woodring Ct., Livonia 48154
Glikman, Victor.....20131 James Couzens, Detroit 48235
Glowacki, Ben F. (L)..............8 Mile & Greenfield, Southfield 48075
Glowacki, Edward T.............20162 Wedgewood Dr., Grosse Pte. Woods 48236
Glowacki, Raymond M......961 Monroe, Dearborn 48124
Godley, Alegro J.........3790 Woodward, Detroit 48201
Goerke, Elmer A......36663 Goddard Rd., Romulus 48174
Goetz, Angus G. (L)............3800 Woodward, #406, Detroit 48201
Goins, Wm. F...1550 Charboneau Pl., #223, Detroit 48207
Goldberg, Arthur........20461 John R. St., Detroit 48203
Goldberg, Harry H. (L)..........2211 Woodward Ave., Detroit 48201
Golden, Alfred..26764 York Rd., Huntington Woods 48070
Goldfaden, Alfred.......9122 W. Fort St., Detroit 48209
Goldman, Aubrey....17191 James Gouzens, Detroit 48235
Goldman, Perry........18050 Fairway Dr., Detroit 48221
Goldman, Robert T...Wayne County Hospital, Eloise 48132
Goldrath, Milton H...............17000 W. 8 Mile Rd., Southfield 48075
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Gollman, Maurice D...........17000 W. Eight Mile Rd., Southfield 48075
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Goodman, Paul A.............Sinai Hosp., Detroit 48235
Goodman, Virgil P....................762 Bedford Rd., Grosse Pte. Park 48236
Goodwin, Warren W. 20101 James Couzens, Detroit 48235
Goodwin, William P......1616 Boston W., Detroit 48206
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Gordon, Seymour V. (A)............Beach Army Hosp., Fort Wolters, Tx. 76067
Gordon, Wm. E..........18058 Greenfield, Detroit 48235
Gorelick, Martin J...23901 Michigan Ave., Dearborn 48124
Goryl, Stephen V.........21501 Kelly, East Detroit 48021
Goss, Saml. B...............10 Peterboro, Detroit 48201
Gostine, Edmond J.........9750 Chalmers, Detroit 48213
Gotham, James E..........3825 Brush St., Detroit 48201
Gotman, Abraham G.............987 E. Jefferson Ave., Detroit 48207
Gottlieb, Jacques S.......951 E. Lafayette, Detroit 48207
Gouda, Salah E. A.......28633 Hoover Rd., Warren 48093
Goux, Raymond S. (L)...........17566 Muirland Ave., Detroit 48221
Grabiel, Amado....................20145 Wedgewood, Grosse Pte. Woods 48236
Grace, Jos. M...31140 Huntley Square, Birmingham
Grady, Jos. A.........946 Three Mile Dr., Detroit 48230
Graham, John G., Jr...491 Lincoln Rd., Grosse Pte. 48236
Graham, Theodore N.........2424 Puritan, Detroit 48238
Granger, Francis L.....14160 Gratiot Ave., Detroit 48205
Granger, George R...........705 David Whitney Bldg., Detroit 48226
Grant, Abraham H...22454 Chatsford Cir., Southfield 48075
Grant, Heman E. (L)....Box 224, Babson Park, Fl. 33827
Gratton, Henri L. (L)..76 W. Adams Ave., Detroit 48226
Gratton, J. Paul V.....Henry Ford Hosp., Detroit 48202
Graves, James H...63 Kercheval, Grosse Pte. Farms 48236
Gray, Howard O............5050 Joy Rd., Detroit 48204
Green, Edward W....2799 W. Grand Blvd., Detroit 48202
Green, Ellis R. (L).....5172 Scotten Ave., Detroit 48210
Green, Henry L.........17214 Jeanette, Southfield 48075
Green, Lewis..........13000 Grand River, Detroit 48227
Green, Milton M...17000 W. 8 Mile Rd., Southfield 48075
Green, Nelson W.................31815 Southfield Rd., Birmingham 48009
Green, Thomas, Jr...........5050 Joy Rd., Detroit 48204
Greenberg, Jack R............15821 W. Seven Mile Rd., Detroit 48235
Greenberg, Julius J.....5328 W. Outer Dr., Detroit 48235
Greenberg, Morris Z.......9105 Van Dyke, Detroit 48213
Greenberg, Stanley....20905 Greenfield, Southfield 48075
Greene, John B.....2179 W. Grand Blvd., Detroit 48208
Greene, Thomas J.......1054 Fisher Bldg., Detroit 48202
Greenlee, Wm. T. (L)...15053 Maddelein, Detroit 48205

Greenslit, Frank S.............U. S. Vets. Admin. Hosp., Dearborn 48121
Greer, Clarence W. (A)......2642 Arndt, Detroit 48207
Gregory, Gertrude B...Ford Tractor Plant, P.O. Box 3622, Highland Park 48203
Gregory, Louis J.........47 Webber Place, Detroit 48236
Griffin, Robert J.........17401 Mack Ave., Detroit 48224
Griffiths, Sydney J.....15400 Plymouth Rd., Detroit 48227
Grifka, Thomas J.....1400 Chrysler Expwy., Detroit 48207
Grimaldi, Gregory J. (A)...2983 Seminole, Detroit 48214
Grinstein, Alexander.....18466 Wildemere, Detroit 48221
Grishkoff, M. A.........2201 E. Jefferson, Detroit 48207
Griva-Lizlovs, Sylvia..29901 Ford Rd., Garden City 48135
Griz, John...........3815 Pelham Rd., Dearborn 48124
Grob, Otto (A)................900 Calle Delosamigos, Santa Barbara, Ca. 93105
Gronemeyer, Wm. H.........1800 Tuxedo, Detroit 48206
Grose, Frederick J...19350 W. 7 Mile Rd., Detroit 48219
Grossman, Solomon C............26339 Woodward Ave., Huntington Woods 48070
Gudes, David S.........1080 Fisher Bldg., Detroit 48202
Guerrero, Jose (L)......13700 Woodward, Detroit 48203
Guevara, Omar......29901 Ford Rd., Garden City 48135
Guevara, Walter..........Lafayette Clinic, Detroit 48207
Guidot, Julian M.....13345 W. McNichols, Detroit 48235
Guimaraes, Abilio S. (L)...........7301 Schaffer Hwy., Dearborn 48126
Guinan, Geo. E. (L)......5012 Howe Rd., Wayne 48184
Guindi, Mounir F.........23580 Geneva, Oak Park 48237
Guindi, Sami F.........1080 Fisher Bldg., Detroit 48202
Guise, Edwin R., Jr...Henry Ford Hospital, Detroit 48202
Gulick, Arthur E.............4160 John R, Detroit 48201
Gurdjian, Elisha S...1553 Woodward Ave., Detroit 48226
Gurskis, Eugenia E.......504 Kales Bldg., Detroit 48226
Gutow, Benjamin R..........20867 Mack, Detroit 48236
Guyon, Jos. F.........Wyandotte Hosp., Rehab. Center, 2331 Van Alstyne Blvd., Wyandotte 48192
Guyton, Jack S......2799 W. Grand Blvd., Detroit 48202
Hacker, Elaine M........763 Fisher Bldg., Detroit 48202
Haddad, Benjamin F...........1010 Mich. Mutual Bldg., Detroit 48226
Haddad, Elias D.....14636 E. Seven Mile, Detroit 48205
Hadesman, Donald.......985 E. Jefferson, Detroit 48207
Hadjimihaloglu, B. S...2429 E. Milwaukee, Detroit 48211
Haefele, Leslie P.....29108 Ford Rd., Garden City 48135
Hagermoser, H. H...412 Eastland Ctr. Bldg., Detroit 48236
Haidostian, B. H.......18456 Grand River, Detroit 48223
Haines, Ellen R............525 Seyburn, Detroit 48214
Haitinger, K. S........22175 Thorofare, Grosse Ile 48138
Haking, Leonard....14014 E. 7 Mile Rd., Detroit 48205
Halekas, G. Peter 21727 Mack Ave., St. Clair Shores 48080
Haley, William A......8339 Mack Avenue, Detroit 48214
Hall, Arch H.............3790 Woodward, Detroit 48201
Hall, C. Robert (A).Detroit General Hosp., Detroit 48226
Hall, E. Walter (L)..14189 Rosemont Rd., Detroit 48223
Hall, Ralph E. (L)..Drummond Island, Drummond 49726
Hall, Richard H..........828 Fisher Bldg., Detroit 48202
Hall, Winthrop D...5237 Oakman Blvd., Dearborn 48126
Hallen, Leonard J........1335 Nicolet Pl., Detroit 48207
Hamaker, Ronald C. (A)..........1721 Gardenia, #11, Royal Oak 48067
Hamburg, Robt. H...........1515 Dav. Whitney Bldg., Detroit 48226
Hamburger, Albert C...13345 W. McNichols, Detroit 48235
Hamburger, Stuart W.............18400 Schaefer Hwy., Detroit 48235
Hamil, Brenton M......Henry Ford Hosp., Detroit 48202
Hammer, Edwin J.......16616 Mack Ave., Detroit 48224
Hammer, Roy W......11455 E. McNichols, Detroit 48234
Hammond, Arthur E. (L).........1553 Woodward Ave., Detroit 48226
Hammond, James L. (L)..............1006 Morse St., Oceanside, Ca. 92054
Handel, Jack E.....Detroit Memorial Hosp., Detroit 48226
Hansen, John W. (R)..........715 W. Michigan Ave., Jackson 49201
Hanyi, Karl..........7645 Thornwood, Plymouth 48170
Hardstaff, R. John (L)...648 Neff Rd., Grosse Pte. 48230
Hardt, Barbara A......1301 Orleans, #303, Detroit 48207
Hardy, Clarence M.......23019 Ecorse Rd., Taylor 48180
Hardy, Geraldine M..................19707 Mack Ave., Grosse Pte. Woods 48236
Hardy, Warren G...801 Dav. Whitney Bldg., Detroit 48226
Harelik, Ely W. (L).............Det. House Correction, Plymouth 48170
Harkaway, Roman W.....19125 Van Dyke, Detroit 48234
Harley, Garth H.......451 Golfcrest Dr., Dearborn 48124
Harley, Louis M...4100 W. McNichols Rd., Detroit 48221
Harm, Winfred B. (L)..........16150 Oxley, Apt. 101, Southfield 48075
Harmon, Edwin L....................745 Bedford Rd., Grosse Pte. Park 48230
Harmon, Walter, Jr...13700 Woodward Ave., Detroit 48203
Harnett, R. W. F.........529 Fisher Bldg., Detroit 48202
Harper, James H...Kirwood General Hosp., Detroit 48238
Harper, Jesse T...1110 Dav. Whitney Bldg., Detroit 48226
Harrington, F. L...15901 W. 9 Mile Rd., Southfield 48075
Harris, A. D...............12815 Linwood, Detroit 48238
Harris, Donald M...517 E. Roosevelt, Battle Creek 49017
Harris, Harcourt G......9141 Dexter Blvd., Detroit 48206
Harris, Harold H. (R)................1221 Drew, C-1, Clearwater, Fl. 33315
Harris, Ivor D....1245 David Whitney Bld., Detroit 48226
Harrity, William A.............302 Eastland Prof. Bldg., Detroit 48236
Hart, Charles E.....23845 Van Dyke, Center Line 48015
Hart, John C. (A)...........9341 Moffat, Detroit 48213
Hart, Zwi H.........800 N. Gulley Rd., Dearborn 48128
Hartkop, Henry H.......20055 Mack Ave., Detroit 48236
Hartquist, Robt. J.......1495 Fort St., Wyandotte 48192
Hartzell, John B.....7815 Jefferson Ave. E., Detroit 48214
Hartzell, John M........7815 E. Jefferson, Detroit 48214
Hasley, Clyde K. (L).........2320 N. Lasalle Gardens, Detroit 48206
Hasley, Danl. E. (R)....16512 Shaftsburg, Detroit 48219
Hassett, Gerard R.....St. Mary's Hospital, Livonia 48151
Hassig, Walter W.......20914 Kelly, East Detroit 48021
Hastings, Orville J......15744 Harper Ave., Detroit 48224
Haszczyc, Vladimir A....3329 Yemans, Hamtramck 48212
Hathaway, Hubert R. (A)..........154 Englewood Rd., Springfield, Oh. 45504
Haubrich, Wm. S.......Henry Ford Hosp., Detroit 48202
Hause, Glen E.........18520 Grand River, Detroit 48223
Hauser, I. Jerome........7411 Third Ave., Detroit 48202
Hauser, John E.............405 Northland Med. Bldg., Southfield 48075
Hauser, Maurice J. (A)...7411 Third Ave., Detroit 48202
Hawash, Raouf R...25701 Joy Rd., Dearborn Hgts. 48127
Hawkins, James W. (L)...........3885 Prudence Drive, Sarasota, Fl. 33580
Hawtof, David B..15901 W. 9 Mile Rd., Southfield 48075
Hayden, Royal C., Jr...Henry Ford Hospital, Detroit 48202
Hayes, Allen L..........17431 Greenfield, Detroit 48235
Hazen, Roy S.........15121 W. 7 Mile Rd., Detroit 48235
Heath, Leonard P....1553 Woodward Ave., Detroit 48226
Heavner, Lyle E.....17700 Mack Ave., Grosse Pte. 48224
Heenan, Theopilus H..............1553 Woodward Ave., Detroit 48226
Heideman, Louis E...3800 Woodward Ave., Detroit 48001
Heil, Edward R........24111 Southfield, Southfield 48075
Heins, Marilyn..........747 Lakeland, Grosse Pte. 48236
Heldt, Richard F.....1951 Monroe Blvd., Dearborn 48124
Heldt, Thos. J. (L)..17 Poplar Park, Pleasant Ridge 48069
Helman, Norman (M)................3828 S. Yosemite, Denver, Co. 80237
Hendelman, Manuel H.......17141 Hayes, Detroit 48205
Henderson, Allison B....9041 Dexter Blvd., Detroit 48206
Henderson, Arthur B. (L)..........946 Beaconsfield Rd., Grosse Pte. Park 48230
Henderson, Chas. W...20905 Greenfield, Southfield 48075
Henderson, Frederic C...18601 Mack Ave., Detroit 48236
Henderson, Hugh W.....18601 Mack Ave., Detroit 48236
Henderson, Leslie T. (L)..18101 E. Warren, Detroit 48224
Henderson, Wm. E. (L)..18601 Mack Ave., Detroit 48236
Hendra, Alan K............15540 Harper, Detroit 48224
Hendrie, Hugh C....................70 Thatcher Dr., Ft. Garry, Manitoba, Canada
Henig, Fred N.....7605 W. Seven Mile Rd., Detroit 48221
Henkin, Raymond......17228 Shervilla, Southfield 48075
Henkin, Wm. A.........18215 Greenfield, Detroit 48235
Hennessey, Alan T.......Oakwood Hosp., Dearborn 48121

Henrich, Laurence E. (L)........18239 W. Seven Mile., Detroit 48219
Henry, Robert C..........1 Lafayette Pl., Detroit 48207
Herbst, Harold B...7282 Riverstone Rd., Birmingham 48010
Hergt, Klaus......10909 W. Jefferson, River Rouge 48218
Hernandez, Hugo R. (A).........Northville State Hosp., Northville 48167
Herrero, Eduardo M...21913 Canterbury, Grosse Ile 48138
Herrero, Eduardo U...21845 Canterbury, Grosse Ile 48138
Herrold, Rose E. (L)..1277 E. Grand Blvd., Detroit 48211
Herschelmann, Roy F....3343 Gratiot Ave., Detroit 48207
Hershey, Ernest A., Jr..........641 Dav, Whitney Bldg., Detroit 48226
Hertzler, Jack H.....3011 W. Grand Blvd., Detroit 48202
Herwick, John T.....2799 W. Grand Blvd., Detroit 48202
Hess, Joseph W. (A)..1401 Rivard St., Wayne State Univ., Detroit 48207
Hessburg, Philip C.....Henry Ford Hosp., Detroit 48202
Heyman, Louis F.............19009 W. Seven Mile Rd., Detroit 48219
Heyner, C. S...............15901 W. 9 Mile Rd., #400, Southfield 48075
Heyner, Fredk. J...........15901 W. 9 Mile Rd., #400, Southfield 48075
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 48204
Hicks, Fredk. G......1000 Westwood, Birmingham 48009
High, Robert H.........Henry Ford Hosp., Detroit 48202
Higuera, J. Gilberto..13700 Woodward Ave., Detroit 48203
Hill, Edward J., Jr.............949 Dav. Whitney Bldg., Detroit 48226
Hill, George C..............5050 Joy Rd., Detroit 48204
Hill, Raymond D......14551 Southfield, Allen Park 48101
Hill, Welford T..........6303 Mack Ave., Detroit 48207
Hillenberg, Sidney J...19350 W. 7 Mile Rd., Detroit 48219
Hiller, Glenn I.............15901 W. 9 Mile Rd., #610, Southfield 48075
Hillyer, John W.........3700 West Road, Trenton 48183
Hilton, Wm. E. (L)........5013 Harding, Detroit 48213
Hinchman, D. F....10865 Farmington Rd., Livonia 48150
Hipps, Chauncey J...2605 West Grand Blvd., Detroit 48208
Hirsch, Leo J.................1190 E. Twelve Mile Rd. Madison Heights 48071
Hirsch, Lore...........212 S. Melborn, Dearborn 48124
Hirschfeld, A. H.........3790 Woodward, Detroit 48201
Hoagland, F. L. (A)..716 E. Grand Blvd., Detroit 48207
Hobbs, Donald V.................27305 Southfield Rd., Lathrup Village 48075
Hochman, Morton M...16633 Plymouth Rd., Detroit 48227
Hodges, Jason......26401 Harper, St. Clair Shores 48081
Hodgkinson, Chas. P.............17546 Meadwood Ave., Lathrup Village 48075
Hoffer, Thos...........5825 Allen Rd., Allen Park 48101
Hoffman, Ben G........19545 Shrewsbury, Detroit 48221
Hoffman, Edward A...7615 W. Vernor Hwy., Detroit 48209
Hoffman, Edwin S. (R)..........8106 E. Jefferson Ave., Detroit 48214
Hoffman, Harry Y.............15085 E. Seven Mile Rd., Detroit 48205
Hoffman, Henry A.....10015 E. Outer Dr., Detroit 48224
Hoffman, Louis...........21701 W. 11 Mile Rd., #9, Southfield 48075
Hoffman, Milton C.......18555 E. Warren, Detroit 48236
Hogikyan, Azat..16901 W. McNichols Rd., Detroit 48235
Holbrook, James M. (A)..3509 Meckl Dr., Warren 48092
Holdredge, Jean M...3011 W. Grand Blvd., Detroit 48202
Hollander, Abraham J.............14327 Michigan Ave., Dearborn 48126
Hollinger, F. Wayne..8265 Gen. Mtrs. Bldg., Detroit 48202
Hollis, Henry B..............6809 Sirena, Detroit 48210
Holloway, Horace R.......12840 Linwood, Detroit 48238
Holloway, Janet L...........7430 Second, Detroit 48202
Hollowell, M. L......10720 W. 7 Mile Rd., Detroit 48221
Holmes, George F.....14729 Champaign, Allen Park 48101
Holt, Chas. J., Jr.......1210 S. Oxford, Grosse Pte. 48236
Holt, Henry T..............5050 Cass St., Detroit 48202
Holt, W. S., Jr.........Mt. Carmel Hosp., Detroit 48235
Homeister, Eugene A..........12925 Pennsylvania Ave., Wyandotte 48192
Honet, Joseph C...........Sinai Hospital, Detroit 48235
Honhart, Fred L. (L)...........1405 Berkshire Road, Grosse Pte. 48230
Hopkins, Andrew J........4407 Roemer, Dearborn 48126
Hopkins, George C............3183 Mack, Detroit 48207
Hopkins, Scovell M...........910 Dav. Broderick Twr., Detroit 48226
Horkins, Earl J.........32300 Schoolcraft, Livonia 48154
Horn, Robt. C., Jr....2799 W. Grand Blvd., Detroit 48202
Hornbeck, Robert J...31500 Schoolcraft Rd., Livonia 48150
Horny, Hugo O........619 Barrington Rd., Detroit 48230
Horrell, Eugene D.......1408 Kales Bldg., Detroit 48226
Horton, Reece H...............606 Northland Med. Ctr., Southfield 48075
Horvath, James J....1553 Woodward Ave., Detroit 48226
Horvitz, Victor S......18400 Schaefer Hwy., Detroit 48235
Hotchkiss, Loris M.......33220 W. 7 Mile, Livonia 48152
Howard, Philip J.......Henry Ford Hosp., Detroit 48202
Howard, William K.........1800 Tuxedo, Detroit 48206
Howell, Bert F.........10800 Whittier Rd., Detroit 48224
Howell, James T.....2799 W. Grand Blvd., Detroit 48202
Howes, Homer A. 1515 Dav. Whitney Bldg., Detroit 48226
Howlett, Howard T.......868 Fisher Bldg., Detroit 48202
Hoyos, Pedro G.....................6085 Campus Dr., Dearborn Hghts. 48127
Hromadko, Louis (L)...1053 Fisher Bldg., Detroit 48202
Hubbard, John P., Jr. (L)......14620 E. Seven Mile Rd., Detroit 48205
Huber, Philip J...........1724 Bassett, Royal Oak 48067
Hudson, J. Stewart (L)................319 Fisher Rd., Grosse Pte. 48230
Hudson, Wm. A. (L).....Hudsonakers, Jasper, Ar. 72641
Hudspeth, E. Rae........763 Fisher Bldg., Detroit 48202
Huebl, Hubert C. (A)...............1212 Shatto Street, Los Angeles, Ca. 90017
Huegli, Wilfred A...16840 E. Warren Ave., Detroit 48224
Huggins, H. Horne..........8355 Gratiot, Detroit 48213
Hughes, Calvin H....19959 Vernier, Harper Woods 48236
Hughes, John A. (A)......4407 Roemer, Dearborn 48126
Hughett, Arthur L....19959 Vernier, Harper Woods 48236
Hulick, Archie G............1600 Tuxedo, Detroit 48206
Hull, Leroy W. (L).....6364 Cowell Rd., Brighton 48116
Hullerman, Hugo V.....Children's Hospital, Detroit 48202
Hume, H. Ross, Jr..........3800 Woodward Ave., #406, Detroit 48201
Humes, James J.........St. John Hospital, Detroit 48236
Huminski, Thaddeus S.............19244 Van Dyke Ave., Detroit 48234
Hummel, Arthur R.....1020 3 Mile Rd., Grosse Pte. 48236
Hunt, Theodore H...19431 Van Dyke Ave., Detroit 48234
Hunt, Verne G. (L)..1553 Woodward Ave., Detroit 48226
Hunter, Donald G.......3245 E. Jefferson, Detroit 48207
Hunter, Robert B.......Henry Ford Hosp., Detroit 48202
Husband, Chas. W. (L)...........14500 W. McNichols, Detroit 48235
Husband, Raymond C..............14500 W. McNichols, Detroit 48235
Hutchins, M. Colton..3011 W. Grand Blvd., Detroit 48202
Hyatt, Jarvis M.....22340 Michigan Ave., Dearborn 48124
Hyde, Fredk. W., Jr........Grace Hospital, Detroit 48201
Hyland, John R.............17200 Mack, Detroit 48224
Hysni, Aliqemal....8031 W. Vernor Hwy., Detroit 48209
Iacobell, Peter H.........19300 Van Dyke, Detroit 48234
Iacobellis, M......22159 W. Outer Drive, Dearborn 48124
Ice, Garnet T........8401 Woodward Ave., Detroit 48202
Iglesias, Luis J. (A)..............3535 W. 13 Mile Rd., Royal Oak 48072
Igna, Eli J..........2799 W. Grand Blvd., Detroit 48202
Ignagni, Antonio.........21470 Sloan Dr., Detroit 48207
Imamoglu, Kamil (A).............1400 Chrysler Expwy., Detroit 48207
Imperio, Napoleon C.............22231 W. Outer Dr., Dearborn 48124
Indenbaum, Samuel..18400 Schaefer Hwy., Detroit 48235
Ine, Myung Yul............1800 Tuxedo, Detroit 48206
Ingberg, Harry O.............261 Brady, Detroit 48201
Irvin, Earle A...Ford Motor Co. America, Dearborn 48121
Irwin, Wm. A........16001 9 Mile Rd., Southfield 48075
Isaacson, Arthur (L).....18989 San Juan, Detroit 48221
Isaacson, Harold E.....15361 Plymouth Rd., Detroit 48227
Isaacson, Jo. D......................26008 Pembroke, Huntington Woods 48070
Ishac, F. F..........38241 Southfarm, Northville 48167
Israel, Barney B.........663 Fisher Bldg., Detroit 48202

Itkin, H. David..........2900 S. Fort St., Detroit 48217
Iwata, Herbert T........7611 Patton Ave., Detroit 48228
Izner, Bernice............16500 North Park Dr., #410, Southfield 48075
Izner, Sanford M..............7946 Ivanhoe St., #302, La Jolla, Calif. 92037
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Jacknow, David..........60 W. Hancock, Detroit 48201
Jackson, Franklin R..........2424 Puritan, Detroit 48238
Jackson, Winston B.........2425 Oakman, Detroit 48238
Jacobs, David M.....10601 W. 7 Mile Rd., Detroit 48221
Jacobs, Howard.........18241 Greenfield, Detroit 48235
Jacobson, Lyle F........5224 St. Antoine, Detroit 48202
Jacobson, Saml. D...Wayne Co. Genl. Hosp., Eloise 48132
Jacobus, Wayne N...20055 Mack Ave., Grosse Pte. 48236
Jaconette, J. R....Mt. Carmel Mercy Hosp., Detroit 48235
Jaeger, Grove A..........11711 Minden, Detroit 48205
Jaekel, Clarence N. (L).........1086 E. Grand Blvd., Detroit 48207
Jaffar, Donald J...........15901 W. 9 Mile Rd., #514, Southfield 48075
Jaffe, Harold W...1706 David Whitney Bl., Detroit 48226
Jaffe, Jacob......11740 Wilshire, Los Angeles, Ca. 90025
Jaffe, Louis..............18662 Muirland, Detroit 48221
Jahsman, Wm. E. (R).........501 Mandalay Ave. G-18, Clearwater Beach, Fla. 33515
Jakacki, Richard Wm.....36157 Sherwood, Livonia 48154
Jamieson, Thos. J. (L)...2058 Ferris, Lincoln Park 48146
Janicki, Natalia J............Eloise Hosp., Eloise 48132
Jarvis, Harold F..............360 Moross, Detroit 48236
Jasion, Lawrence J. (A).....11945 Payton, Detroit 48224
Jaynes, Richard V.....29901 Ford Rd., Garden City 48135
Jeffries, Benj.....19959 Vernier Rd., Harper Woods 48236
Jend, Wm., Jr...........1365 Cass Ave., Detroit 48226
Jenkins, Elwood A.............610 Dav. Whitney Bldg., Detroit 48226
Jennings, Chas. G...356 Hillcrest, Grosse Pte. Farms 48236
Jensen, Viggo W..........17850 Maumee, Detroit 48230
Jevons, William H..8425 Twelve Mile Rd., Warren 48093
Jewell, F. C...........7220 Gratiot Ave., Detroit 48213
Jewell, John S..2021 Monroe, Suite 203, Dearborn 48124
Jewell, Marvin R.......Childrens Hospital, Detroit 48202
Jocz, Marion W.........945 Trombley Rd., Detroit 48230
Jodar, Emery O.........15760 Mack Ave., Detroit 48224
Jodar, Loyal W.........18412 Mack, Grosse Pte., 48236
John, Hubert R. (L)..20905 Greenfield, Southfield 48075
Johnson, Aran S....................642 Blairmoor Ct., Grosse Pte. Woods 48236
Johnson, Arthur J.....Henry Ford Hospital, Detroit 48202
Johnson, Gage...........2785 S. Fort St., Detroit 48217
Johnson, Rodger L...1369 Westwood, Birmingham 48009
Johnson, Thos. D.....18530 Grand River, Detroit 48223
Johnson, Verne E.....2051 Monroe Ave., Dearborn 48124
Johnson, Vernon P.................21327 Harper Ave., St. Clair Shores 48080
Johnson, Wilbur E..........14654 Gratiot, Detroit 48205
Johnson, Wm. H. M. (L) 7157 63 Michigan, Detroit 48210
Johnston, Everett V. (L)...........30130 Bristol Lane, Birmingham, 48010
Johnston, Herbert C.........Ford Motor Co., Rouge Pl., 3001 Miller Rd., Dearborn 48121
Johnston, Jos. A. (L)...Henry Ford Hosp., Detroit 48202
Johnston, Wm. E. (L)............3011 W. Grand Blvd., Detroit 48202
Johnstone, Benj. I. (L)...............31 Oakland Park, Pleasant Ridge 48069
Joinville, Euclide V. (L)..1202 Stroh Bldg., Detroit 48226
Jones, Arnold M..........3706 Sturtevant, Detroit 48206
Jones, Don P.........Wayne State Univ., Detroit 48207
Jones, G. Richard.......18412 Mack Ave., Detroit 48236
Jones, Roy D. (L).....10234 Puritan Ave., Detroit 48238
Jones, Wm. J..........8209 Allen Rd., Allen Park 48101
Joos, Thad. H........20340 Harper, Harper Woods 48236
Jordan, Prescott, Jr......5224 St. Antoine, Detroit 48202
Jordan, R. Gerald.......12410 Van Dyke, Detroit 48234
Joseph, Ramon R....Wayne Co. Gen. Hosp., Eloise 48132
Joshi, Daya P........987 E. Jefferson Ave., Detroit 48207
Joyce, Stanley J. (L)..........2040 W. McNichols Rd., Detroit 48203
Joyrich, Myron H.........Sinai Hospital, Detroit 48235
Juliar, Benj.........17305 Muirland Ave., Detroit 48221
Juliar, Joseph F...........17526 Oak Dr., Detroit 48221
Juncker, John B. (M)...Oakwood Hosp., Dearborn 48124
Jungwirth, R. V...19350 W. McNichols Rd., Detroit 48219
Kackley, James E...........18495 Mack, Detroit 48236
Kain, Thomas R.....3245 E. Jefferson Ave., Detroit 48207
Kaine, Henry D......3011 W. Grand Blvd., Detroit 48202
Kalayjian, Bernard S...30676 Harlincin Ct., Franklin 48025
Kalichman, Nathan.......19304 Wyoming, Detroit 48221
Kallenbach, Rudolph W....388 Inkster Rd., Inkster 48141
Kallet, Herbert I. (L)....651 Fisher Bldg., Detroit 48202
Kallet, Maerit B.............1800 Tuxedo, Detroit 48206
Kallman, David (L)..2351 W. Grand Blvd., Detroit 48208
Kallman, Leo.........2351 W. Grand Blvd., Detroit 48208
Kallman, Reuben R...2631 Woodward Ave., Detroit 48201
Kambouris, Angelos A...........744 Dav. Whitney Bldg., Detroit 48226
Kamil, Richard S........14438 McNichols, Detroit 48235
Kandel, Robert F.......Henry Ford Hosp., Detroit 48202
Kane, Archibald V............Box 1108, Northland Ctr., Southfield 48075
Kansa, Selma...........19431 Van Dyke, Detroit 48234
Kantor, Sheldon M.........19207 Schaefer, Detroit 48235
Kapetansky, Don I........17376 Schaefer, Detroit 48235
Kapetansky, Nathan J.......17376 Schaefer, Detroit 48235
Kaplita, Walter A...................60 Fontana Lane, Grosse Pte. Shores 48236
Kapphahn, K. H........Henry Ford Hosp., Detroit 48202
Kapreilain, Michael...............189 Townsend # 210, Birmingham 48011
Karabeyoglu, Turgut..............Northville State Hosp., Northville 48167
Karadeloglou, B.........817 Virginia Park, Detroit 48202
Karamatas, Philip C...10822 W. Warren, Dearborn 48126
Karch, Saul..............18080 Muirland, Detroit 48221
Kasabach, Harry Y...1553 Woodward Ave., Detroit 48226
Kashtan, Harry A.....15201 W. McNichols, Detroit 48235
Kasper, Jos. A. (L)..................1011 Cadieux Rd., Grosse Pte. Park 48230
Kaspor, Albert J........20901 Moross Rd., Detroit 48236
Kass, Arnold......1316 David Stott Bldg., Detroit 48226
Katz, Lawrence..........987 E. Jefferson, Detroit 48207
Katz, Martin.......12794 Veronica Dr., Southgate 48192
Katzman, Irving S.........848 Fisher Bldg., Detroit 48202
Kaufman, Jack H........17421 Greenfield, Detroit 48235
Kaufman, Louis W...10326 W. Seven Mile, Detroit 48221
Kaufman, William H............10149 Michigan Ave., Dearborn 48126
Kawchak, James.......Ford Motor Co., Dearborn 48121
Kawecki, Lucian....................10734 Hart Ave., Huntington Woods 48070
Kawel, Conrad A., Jr.............10955 Farmington Rd., Livonia 48150
Kayi, Cengiz.....Northville State Hosp., Northville 48167
Kazdan, Morris.......4619 Allen Road, Allen Park 48101
Keemer, Edgar B. Jr...........1111 David Whitney Bldg., Detroit 48226
Kehoe, Henry J........15252 Gratiot Ave., Detroit 48205
Keith, Rachel H. C. B.......5050 Joy Rd., Detroit 48204
Kelin, Maximilian.................5133 Nob Hill Ct., Bloomfield Hills 48013
Kelley, Frank J..........853 Fisher Bldg., Detroit 48202
Kelly, A. P., Jr.........Henry Ford Hosp., Detroit 48202
Kelly, Edward W., Jr......156 Harmon St., Detroit 48202
Kelly, John J.........14729 Champaign, Allen Park 48101
Kelly, L. J................14015 Gratiot, Detroit 48205
Kelmenson, Victor A........7356 12th St., Detroit 48206
Kelson, Malcolm J...........1045 Harvard, Detroit 48230
Kennary, James M......4900 Cadieux Rd., Detroit 48224
Kennary, James M., Jr...4900 Cadieux Rd., Detroit 48224
Kennedy, Donald J...............410 North Shore Drive, St. Clair Shores 48080
Kermath, James E.....15101 Southfield, Allen Park 48101
Kernick, Melvin O.............13700 Woodward Ave., Highland Park 48203
Kerwin, George R...22149 Chatsford Cir., Southfield 48075
Kessel, Karl J........21421 Kelly Rd., East Detroit 48224
Kessler, Chas............18241 Greenfield, Detroit 48235
Keyes, John W.........Henry Ford Hosp., Detroit 48202
Killins, Chas. G.........8100 E. Jefferson, Detroit 48214
Kimberlin, K. K., Jr...11110 Morang Drive, Detroit 48224
King, Edward D. (L)......270 Rivard, Grosse Pte. 48230

King, Melbourne J...5435 W. Vernor Hwy., Detroit 48209
Kingswood, Roy C. (L)...........14310 Hamilton Ave., Highland Park 48203
Kitzmiller, John L...15901 W. 9 Mile Rd., Southfield 48075
Klaiber, Roger G........1541 Edsel Drive, Trenton 48183
Klein, Herman.......5030 Wallbrook, Birmingham 48010
Klein, Howard A.............1846 Dav. Whitney Bldg., Detroit 48226
Klein, Sander P...14825 W. McNichols Rd., Detroit 48235
Kleinman, Shmarya (L).....1800 Tuxedo, Detroit 48206
Klicka, Karl S.............33101 Annapolis, Wayne 48184
Kliger, David (L).........7756 Southfield, Detroit 48228
Klimchuk, M. M.....22770 Kelly Rd., East Detroit 48021
Klimkowski, Edw. J...........17301 W. Eight Mile Rd., Detroit 48235
Kling, George A..........Harper Hospital, Detroit 48201
Kling, Murray G.....22341 W. Eight Mile, Detroit 48219
Kluck, Clarence J.......25210 Grand River, Detroit 48240
Klutke, Geo. H. E.........2841 Monroe, Dearborn 48124
Knaggs, Earl J..........2387 Fort St., Wyandotte 48192
Knapp, Floyd B. (R)............202 Maple Grove Ave., Prudenville 48651
Knapp, Gary H............23611 Goddard, Taylor 48180
Knapp, Gordon R. (R)..........Virginia Madison Apts., Galax, Virginia 24333
Knapp, Wm. L...27740 Devonshire Dr., Southfield 48075
Knighton, Robt. S...2799 W. Grand Blvd., Detroit 48202
Knobloch, Edmund J. (L)..5933 Chene St., Detroit 48211
Knott, Stuart A...........100 Oak St., Wyandotte 48192
Knox, Ross M.........3180 Fort St., Lincoln Park 48146
Kobernick, Sidney D.....6767 W. Outer Dr., Detroit 48235
Kobiljak, Stefan H...3516 Fort Street, Lincoln Park 48146
Kochkodan, Eugene J.............2799 W. Grand Blvd., Detroit 48202
Koebel, Raymond H. (L)............409 N. Shore Dr., St. Clair Shores 48080
Koek, Hans J.........23100 Cherry Hill, Dearborn 48124
Koerber, Edward J....4876 Lakeview Ave., Detroit 48215
Kogan, Natalio............Sinai Hospital, Detroit 48235
Kogut, Constantine S.......10627 Puritan, Detroit 48238
Kokowicz, Raymond J.....19440 Van Dyke, Detroit 48234
Kolman, Isadore I...........1800 Tuxedo, Detroit 48206
Kondomerkos, John D...33020 Palmer Road, Wayne 48184
Kong, Leighton N. L.........Grace Hosp., Detroit 48201
Konno, Edward T.......1400 Chrysler Fwy., Detroit 48207
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Koren, Louis......1300 Cadillac Sq. Bldg., Detroit 48226
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Korum, Lyle W.......18585 E. Warren St., Detroit 48236
Koschnitzke, H. K.....15101 Southfield, Allen Park 48101
Kossayda, Adam W...............15324 Michigan Ave., Dearborn 48126
Kovach, Emery P.........9750 Chalmers, Detroit 48213
Kovan, Dennis D..................16965 Hamilton Ave., Highland Park 48203
Kowaleski, John J.......12789 Veronica, Southgate 48192
Kozlinski, Anthony E...2195 E. Grand Blvd., Detroit 48211
Krabbenhoft, K. L.........3825 Brush St., Detroit 48201
Kraft, Raymond B. (R)............700 S. Ocean Blvd., Boca Raton, Fl. 33432
Kraft, Ruth M...19164 Devonshire Rd., Birmingham 48009
Krakauer, Bernard...........17716 W. Seven Mile Rd., Detroit 48235
Krass, Edward W.......11088 Gratiot Ave., Detroit 48213
Kraus, John J.......16840 E. Warren Ave., Detroit 48224
Krawec, Charles J.............Mt. Carmel Mercy Hosp., Detroit 48235
Krebs, Wm. T.......16419 E. Warren Ave., Detroit 48224
Kreinbring, Geo. E....14295 E. 7 Mile Rd., Detroit 48205
Kretzschmar, John C...660 E. Grand Blvd., Detroit 48207
Krevsky, David A.......8449 Park Ave., Allen Park 48101
Krevsky, Harold.......8449 Park Ave., Allen Park 48101
Krevsky, Seymour..Detroit Memorial Hosp., Detroit 48226
Krieg, Earl G. (A)..757 Middlesex, Grosse Pte. Park 48236
Krieger, Harley L. (R)..11390 Strathmoor, Detroit 48227
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Kroha, Lawrence A...15124 Kercheval Ave., Detroit 48230
Krohn, Lawrence H...........24340 W. McNichols Rd., Detroit 48219
Kroll, H. Harvey V.......7815 E. Jefferson, Detroit 48214
Krull, Edward A.....482 Rivard Blvd., Grosse Pte. 48230
Krynicki, Francis X. (L)..15101 W. 7 Mile, Detroit 48235
Krystal, Henry..............19210 Coyle, Detroit 48235
Kubanek, Jos. L. (L).....23134 Myrtle, Dearborn 48128
Kucmierz, Francis S...18934 Van Dyke Ave., Detroit 48234
Kuehn, Ned N...20203 Wellesley Blvd., Birmingham 48010
Kuhn, Albert A....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Henry H.....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Richard F.......1700 Junction Ave., Detroit 48209
Kujawski, Walter F............17800 E. Eight Mile Rd., Detroit 48236
Kullman, Harold J. (A)..930 Beechmont, Dearborn 48124
Kuran, Lionel V........14853 Michigan, Dearborn 48126
Kurcz, Jos. A.........7433 Michigan Ave., Detroit 48210
Kurtz, Irvin J..........25210 Grand River, Detroit 48240
Kurtzman, Raymond S...........Detroit Memorial Hosp., Detroit 48226
Kutsche, John D............3794 Fort St., Trenton 48183
Kvietys, Benj.............27235 Joy Rd., Dearborn 48127
Kwasiborski, S. A........2300 Oak St., Wyandotte 48192
Kyle, Wm. V., Jr...........4741 Spokane, Detroit 48204
Laberge, James M............100 Oak, Wyandotte 48192
Lackey, Lawrence S............525 Visger, Ecorse 48229
LaCroix, George E...695 Vaughan, Bloomfield Hills 48013
Laderach, David C.........1704 Iroquois, Detroit 48214
Lafata, Philip J.........15260 Levan Rd., Livonia 48154
La Ferte, Alfred D. (L)..667 Neff Rd., Grosse Pte. 48230
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Lahood, Michael J.......20001 Greenfield, Detroit 48235
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Lake, Robt. C...........8445 E. Jefferson, Detroit 48214
Lakin, Alan C...........17431 Greenfield, Detroit 48235
Lakin, Mervyn H...............18900 W. Ten Mile Rd., Southfield 48075
Lakoff, Chas. B. (L)............8233 W. Chicago Blvd., Detroit 48204
Lam, Conrad R.........Henry Ford Hosp., Detroit 48202
Lamberson, Frank A....19001 Grand River, Detroit 48223
Lammy, James V............20867 Mack, Detroit 48236
Lamont, Richard L.....3815 Pelham Rd., Dearborn 48124
Lamontagne, Gaetan.....15830 Fort St., Southgate 48192
Lampman, Harold H. (L)........3011 W. Grand Blvd., Detroit 48202
Landers, Maurice B...275 W. Grand Blvd., Detroit 48216
Lang, Ernst F...........3790 Woodward, Detroit 48201
Lange, Wm. A.......3790 Woodward Ave., Detroit 48201
Langston, John D.....1420 St. Antoine St., Detroit 48226
Laning, Geo. M. (L)..R. D. Morey Rd., Sharon, Ct. 06069
Lansing, Eugene H......33020 Palmer Rd., Wayne 48184
Lansky, Mandell........16339 E. Warren, Detroit 48224
Large, Alfred M...701 Dav. Whitney Bldg., Detroit 48226
Largo, Donald J..........16717 Warwick, Detroit 48219
Larkin, Duane R.........28435 Plymouth, Livonia 48150
Larned, Richard I.........15208 Bringard, Detroit 48205
Larsen, Edward G.......1803 Trenton Dr., Trenton 48183
Larsen, Robt. D........76 W. Adams Ave., Detroit 48226
Larson, Chas. J......12729 Cunningham, Southgate 48192
Larsson, Bror H. (L)....81 E. Kirby Ave., Detroit 48202
Lasichak, Andrew G....76 W. Adams Ave., Detroit 48226
Lasley, James W...1014 David Whitney Bl., Detroit 48226
Latimer, Fredk. R..........28 W. Adams, Detroit 48226
Latteier, Karl K.....15025 W. 8 Mile Rd., Detroit 48235
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Lauppe, Fredk. A....1553 Woodward Ave., Detroit 48226
Laura, Albert L...........9105 Harrison, Livonia 48150
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Lawand, Frank K.............952 David Whitney Bldg., Detroit 48226
Lawrence, Louis F..............15901 W. 9 Mile Rd., Southfield 48075
Lazar, Morton R.......20905 Greenfield, Southfield 48075
Leach, David............430 Fisher Bldg., Detroit 48202
Leach, Robt. B...........1401 Rivard St., Detroit 48207

Leach, Wendell L.......10811 E. Warren, Detroit 48214
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Lebamoff, Alexander T...7940 Allen Rd., Allen Park 48101
Lechner, Monroe S...22770 Kelly Rd., East Detroit 48021
Lecklider, A. F. (R)..848 Berkshire Rd., Grosse Pte. 48230
Lee, Frank........501 Meadowlane Dr., Dearborn 48124
Lee, Harry E. (L)....13616 Gratiot Ave., Detroit 48205
Lee, Pyong Tai....15901 W. 9 Mile Rd., Southfield 48075
Leeser, Robert L...23100 Cherry Hill Rd., Dearborn 48124
Lehmann, Robert N...........26029 West Five Mile Rd., Detroit 48229
Leipsitz, Louis S..........3566 Cass Ave., Detroit 48201
Leiter, Forrest C..........2355 Monroe, Dearborn 48124
Leithauser, Daniel J. (L)..........80 Lakeshore Lane, Grosse Pointe Shores 48236
Leland, Louis S...867 Grosse Pte. Court, Grosse Pte. 48230
Leland, Solomon.........6563 Grand River, Detroit 48208
Lemley, Clark F. (L) 3011 W. Grand Blvd., Detroit 48202
Lemon, Bruce K.......20905 Greenfield, Southfield 48075
Lentine, James J........15831 Mack Ave., Detroit 48224
Lenz, Willard R...........418 Moran Rd., Detroit 48236
Lepard, Cecil W.....1553 Woodward Ave., Detroit 48226
Lepley, Fred O. (L)................19799 Mack Ave., Grosse Pte. Woods, 48236
Lepley, Frederick J.......19803 Mack, Grosse Pte. 48236
Lerman, Saml. I...........18330 Parkside, Detroit 48221
Lerner, A. Martin.....1400 Chrysler Exp., Detroit 48207
Lerner, Leonard H.............7310 W. Seven Mile Rd., Detroit 48221
LeRoy, George V............1800 Tuxedo, Detroit 48206
Lesesne, John M...17700 Mack Ave., Grosse Pointe 48236
Leslie, C. G.............8401 Woodward, Detroit 48202
L'Esperance, Simon P. L. (R)...........18707 Freeland Detroit 48235
Lessani, Nasi D......36180 Five Mile Rd., Livonia 48154
Lessem, David...12759 Vernon, Huntington Woods 48070
Lester, Melvin A.................26831 Woodward Ave., Huntington Wds. 48070
Leszynski, Jos. S. (L)....8120 E. Jefferson, Detroit 48214
Leucutia, Traian (L)........10 Peterboro, Detroit 48201
Levagood, Floyd B.......3790 Woodward, Detroit 48201
Levant, Arthur B........15715 E. Warren, Detroit 48224
Levenson, Malcolm L......24500 Custis, Southfield 48075
Leventer, Ira....20211 Ann Arbor Trail, Dearborn 48127
Levick, Walter G....19959 Vernier, Harper Woods 48236
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Levin, Herbert G..........17300 Schaefer, Detroit 48235
Levin, M. Mitchel.....20905 Greenfield, Southfield 48075
Levin, Saml. J.......3011 W. Grand Blvd., Detroit 48202
Levine, Edward E....................12891 Sherwood, Huntington Woods 48070
Levitt, Irving........24535 N. Carolina, Southfield 48075
Levitt, Nathan (L).......607 Kales Bldg., Detroit 48226
Levy, David B.............29586 Fenkell, Livonia 48151
Levy, Marvin B...23200 Woodward Ave., Ferndale 48220
Levy, Stanley H.....10601 Seven Mile Rd., Detroit 48221
Lewin, Harry (L)...27012 Knob Woods, Southfield 48075
Lewis, Benjamin M..........1401 Rivard, Detroit 48207
Lewis, Harvey Y...14219 W. McNichols Rd., Detroit 48235
Lewis, J. Hugh (L)....1543 Ford Ave., Wyandotte 48192
Lewis, Lee A.......2730 E. Jefferson Ave., Detroit 48207
Lewis, Robt. H....17401 Roseland, Lathrup Village 48075
Lewis, Wilfrid J..........10 Peterboro St., Detroit 48201
Libbrecht, Robt. V.....6540 Park Ave., Allen Park 48101
Lichter, Max L...2900 Oakwood Blvd., Melvindale 48127
Lichty, Dorman E.......7701 Wyoming, Dearborn 48126
Liddicoat, Arthur G. (L)....20125 Fenkell, Detroit 48223
Lie, Kim K..............1408 Kales Bldg., Detroit 48226
Lieberman, Barnard L...........19212 Woodward Ave., Detroit 48203
Lightbody, James J. (L)..7815 E. Jefferson, Detroit 48214
Lightbourn, George A.....18984 Livernois, Detroit 48221
Lignell, Rudolph W..........401 Northland Med. Bldg., Southfield 48075
Liioi, Joseph A.....17000 W. 8 Mile Rd., Southfield 48075
Lilly, Robert P.......15240 Merriman Rd., Livonia 48154
Lindner, David W....3800 Woodward 822, Detroit 48201
Linkner, Leonard S..............12944 La Salle Lane, Huntington Woods 48070
Lipinski, Stanley L.....7540 Michigan Ave., Detroit 48210
Lipkin, Ezra (L).....5715 Michigan Ave., Detroit 48210
Lipnik, Carl E.......31610 Plymouth Rd., Livonia 48150
Lipnik, Morris J...17000 W. Eight Mile, Southfield 48075
Lipschutz, Louis S...19750 Chesterfield Rd., Detroit 48221
Lipson, Channing T...20101 James Couzens, Detroit 48235
Lipson, Madeleine L.........1800 Tuxedo, Detroit 48206
Lipton, Raymond F.......10 Peterboro St., Detroit 48201
Litsky, Abraham D.....1183 E. Grand Blvd., Detroit 48211
Little, James W. 3637 Franklin Rd., Bloomfield Hills 48013
Litwin, Jack A....15121 W. McNichols Rd., Detroit 48235
Litzenberger, D. J......2429 Oakwood, Melvindale 48127
Livingood, Clarence S...345 University, Grosse Pte. 48236
Livingston, W. C.............10720 W. Seven Mile Rd., Detroit 48221
Lloyd, James R...1515 Dav. Whitney Bldg., Detroit 48226
Lo, Lien Fu................1800 Tuxedo, Detroit 48206
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Lockhart, Edward C........7569 Tireman, Detroit 48204
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Logrippo, Annie B.....Henry Ford Hosp., Detroit 48202
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London, Berton L..........18510 Meyers, Detroit 48235
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Longo, Salvatore............468 Cadieux, Detroit 48230
Loomis, John L.......236 Visger Rd., River Rouge 48218
Loomus, Gerald N.....4100 W. McNichols, Detroit 48221
Lopatin, Reuben....22161 W. Outer Dr., Dearborn 48124
Lopez, Rodolfo (A)........Grace Hospital, Detroit 48201
Loranger, C. B. P............20825 Mack, Detroit 48236
Lorber, Jos. H.........873 Lakewood Ave., Detroit 48215
Lorentzen, Edwin H. (L).......11702 Grand River Ave., Detroit 48204
Lovas, Wm. S.........3577 Fort St., Lincoln Park 48146
Love, Donald M..............32665 Utica, Fraser 48026
Love, James M..........16565 Bentler St., Detroit 48219
Lowe, Adolph W...3338 W. Davison Ave., Detroit 48238
Lowinger, Paul L.........951 E. Lafayette, Detroit 48207
Lowrie, Wm. L. (L)..2799 W. Grand Blvd., Detroit 48202
Luby, Elliot D.........19680 Roslyn Rd., Detroit 48221
Lucas, Robert J..........771 Fisher Bldg., Detroit 48202
Lui, Alfred H. F...Wayne Co. Gen. Hospital, Eloise 48132
Lumpkin, John G., Jr...243 E. Warren Ave., Detroit 48201
Lutz, Earl F. (R)..................2920 N. E. 55th St., Ft. Lauderdale, Fl. 33308
Lutz, Sherwin J......15121 W. McNichols, Detroit 48235
Luz, Denis A.....Bon Secours Hospital, Grosse Pte. 48236
Luzadre, John H.........18430 Mack Ave., Detroit 48236
Lynn, David H.......Lynn Hospital, Lincoln Park 48146
Lynn, Harvey D.......3815 Pelham Rd., Dearborn 48124
Lytle, Robt. P...............402 Northland Med. Bldg., Southfield 48075
Maben, Hayward C., Jr...554 Fisher Bldg., Detroit 48202
Mabley, John D. (L)..1037 David Whitney, Detroit 48226
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MacGregor, Wm. W. (L)......1111 N. Woodward Ave., Birmingham 48011
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Mack, Robert E.........Womans Hospital, Detroit 48201
Mac Kenzie, Earle D. (L)..81 E. Kirby St., Detroit 48202
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Maisel, Harry...........19980 Renfrew, Detroit 48221
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Malone, John M.......17300 Schaefer Rd., Detroit 48235
Malone, Robert E.....15101 Southfield, Allen Park 48101
Maloney, John A. (L)...........670 Maccabees Bldg., Detroit 48202
Maloney, Philip J......16401 Grand River, Detroit 48227
Maltzer, Jos. H.....26505 John R., Madison Hghts. 48071
Mammel, Bernard T...........14447 W. Seven Mile Rd., Detroit 48235
Mancuso, Vincent S. (L)..........611 S. W. 38th Ave., Ft. Lauderdale, Fl. 33312
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Mandelbaum, B...........432 E. Hancock, Detroit 48201
Mandell, Gerald H.........Sinai Hospital, Detroit 48235
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Mankani, Hari B.......2000 Second Ave., Detroit 48226
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Marcus, Edwin L.....15101 Southfield, Allen Park 48101
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Margules, Saul Z.....11846 E. McNichols, Detroit 48205
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Markey, Alexander P.............14853 Michigan Ave., Dearborn 48126
Markey, Frank R..........17174 Fairfield, Detroit 48221
Markoe, Rupert C. L. (L)..7600 John R St., Detroit 48202
Marks, Ben.....232 W. Grand River Ave., Detroit 48226
Marks, Bert W......................8250 Lincoln Dr., Huntington Woods 48070
Marsh, Alton R. (L).............15696 Woodland Dr., Dearborn 48120
Marshall, James R. (L).........14827 E. Jefferson Ave., Detroit 48215
Marshall, J. R., Jr.......20160 Mack Ave., Detroit 48236
Martin, J. B., Jr.......449 E. Elizabeth St., Detroit 48201
Martin, Lyndle R......2000 Second Blvd., Detroit 48226
Martin, Peter A.........857 Fisher Bldg., Detroit 48202
Martin, Walter..........13800 Livernois, Detroit 48238
Martin, Wilbur C.......10401 W. Chicago, Detroit 48204
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Marwil, Thos. B...21751 W. 11 Mile Rd., Southfield 48075
Marvin, Robert C.........22362 Morley, Dearborn 48124
Mascarin, T. A..........18101 E. Warren, Detroit 48224
Mathis, Perry L..........3239 Clements, Detroit 48238
Matthews, Burton V...13724 W. Fort St., Southgate 48192
Mattman, Paul E..........1500 Seminole, Detroit 48214
Mattson, Theo. M.....901 W. Grand Blvd., Detroit 48208
Mauch, Eugene W....15101 Southfield, Allen Park 48101
Mauthe, Harry G........16859 Pollyana Dr., Livonia 48154
Maynard, Fredk. M.....6828 Park Ave., Allen Park 48101
Mays, William O.........19737 Cheyenne, Detroit 48235
Maywood, F. N. 20840 Vernier Rd., Harper Woods 48236
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McCall, Marion G., Jr............2930 W. Grand Blvd., Detroit 48202
McCandless, Virginia....270 S. Melborn, Dearborn 48124
McCaughey, R. S.....Wayne St. University, Detroit 48207
McClellan, Robt. J....16345 W. McNichols, Detroit 48235
McClelland, Rachael L.............33026 Five Mile Rd., Livonia 48154
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McClure, Robt. W.......9111 E. Outer Dr., Detroit 48213
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McCollum, E. Bert..........20867 Mack, Detroit 48236
McCord, Carey P. (L)...........Sch. of Public Health, Ann Arbor 48104
McCormick, Colin C. (A).........24352 Rockford Ave., Dearborn 48124
McCue, Francis B......7106 Park Ave., Allen Park 48101
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McCutcheon, Sue A....Henry Ford Hosp., Detroit 48202
McDonald, Angus L. (L)....15125 Gratiot, Detroit 48205
McDonald, John R..........Harper Hosp., Detroit 48201
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McEvitt, Wm. G.....1140 W. Boston Blvd., Detroit 48202
McGee, T. Manford.....22000 Greenfield, Oak Park 48237
McGinnis, Kenneth D...6071 W. Outer Dr., Detroit 48235
McGlaughlin, N. D...2312 Biddle Ave., Wyandotte 48192
McGough, Jos. M......18716 Grand River, Detroit 48223
McGuire, John F..........3815 Pelham, Dearborn 48124
McHenry, John T..........1401 Rivard St., Detroit 48207
McIntosh, C. W.......8355 Gratiot Ave., Detroit 48213
McIntosh, Robt. D.......6307 W. Fort St., Detroit 48209
McIntyre, Wm. B.............1145 Dav. Whitney Bldg., Detroit 48226
McKean, G. Thos....1553 Woodward Ave., Detroit 48226
McKeever, Geo. E...5237 Oakman Blvd., Dearborn 48126
McKenna, Chas. J........14618 E. 7 Mile, Detroit 48205
McKnight, Robt. E...............15901 W. 9 Mile Rd., Southfield 48075
McLane, Harriet I. E. (L).1367 Nicolet Pl., Detroit 48207
McLaughlin, James T............Wyandotte Gen. Hosp., Wyandotte 48192
McLaurin, Jasper E.........5050 Joy Rd., Detroit 48204
McLean, Brita R...............1365 Cass, Detroit 48226
McLean, Don W.........1066 Fisher Bldg., Detroit 48202
McLean, Donald C.......459 Fisher Bldg., Detroit 48202
McManamon, Thomas V. Ford Motor Co., Dearborn 48127
McNamara, Joseph M.....9430 S. Main, Plymouth 48170
McNeill, Roger F........63 Kercheval, Grosse Pte. 48236
McNichol, L. J...18424 W. McNichols Rd., Detroit 48219
McPhee, Roderick T.....................21503 Harper, St. Clair Shores 48080
McQuiggan, Mark R.........700 Seward, Detroit 48202
Meara, Joseph F......Detroit Mem. Hosp., Detroit 48226
Mediodia, Gil H.......22101 Moross Rd., Detroit 48236
Meek, Stuart F.........29542 Hoover Rd., Warren 48093
Melander, L. W., Jr..........1229 David Whitney Bldg., Detroit 48226
Mellen, Hyman S........16800 Greenfield, Detroit 48235
Mellinger, Raymond C...959 Pemberton, Grosse Pte. 48236
Melnik, Maxim P.....3011 W. Grand Blvd., Detroit 48202
Melnyczuk, Nestor......19600 W. Warren, Detroit 48228

Menczer, Richard....................29081 Dequindre, Madison Heights 48071
Mendelson, Herbert....15200 Northfield, Oak Park 48237
Mendelssohn, A. N.....8100 E. Jefferson, Detroit 48214
Mendelssohn, Reuben J..........8100 E. Jefferson Ave., Detroit 48214
Mendians, Edgar V......9486 Beaconsfield, Detroit 48224
Mendoza, Saml............6356 Michigan, Detroit 48210
Menton, Norman J....15300 W. McNichols, Detroit 48235
Mercader, Rodolfo S.....35337 W. Warren, Wayne 48184
Merkel, Chas. C....................85 Kercheval Ave., Grosse Pte. Farms 48236
Merkle, Karl..........530 N. Telegraph, Dearborn 48128
Merrill, C. R., Jr..........1951 Monroe, Dearborn 48124
Merritt, Earl G...........3790 Woodward, Detroit 48201
Mersky, Charlotte I. (A)............32215 Queensboro, Farmington 48024
Metes, John S.....62 Webber Pl., Grosse Pte. Shores 48236
Metzger, Harry C.....................25504 Wareham, Huntington Woods 48070
Meyer, Eugene.........15830 Fort St., Southgate 48192
Meyer, John S.........Wayne State Univ., Detroit 48207
Meyer, Kenneth R.......Oakwood Hosp., Dearborn 48124
Meyers, Marjorie P.......3790 Woodward, Detroit 48201
Meyers, Maurice P.....6767 W. Outer Dr., Detroit 48235
Michael, Cleon M.......32300 Schoolcraft, Livonia 48150
Michael, Michael J..........15901 W. 9 Mile Rd., #400, Southfield 48075
Migdoll, David.......15361 Plymouth Rd., Detroit 48227
Mihay, Benjamin.........2021 Monroe, Dearborn 48124
Mikesell, W. B., Jr.........23611 Goddard, Taylor 48180
Mikhail, George.......Henry Ford Hosp., Detroit 48202
Milauskas, A. T.......100 Oak Street, Wyandotte 48192
Mileris, Vytautas....2730 E. Jefferson Ave., Detroit 48207
Millard, Glenn E.........958 Fisher Bldg., Detroit 48202
Miller, Antonina.......16989 Farmington, Livonia 48154
Miller, Danl. H.......23100 Cherry Hill, Dearborn 48124
Miller, Elmer B...7 John Glenn Place, Highland Park 48203
Miller, George W...................26401 Harper Ave., St. Clair Shores 48080
Miller, Jacob J.......20131 James Couzens, Detroit 48235
Miller, J. Martin....2799 W. Grand Blvd., Detroit 48202
Miller, Jose W..........Childrens Hosp., Detroit 48202
Miller, Karl L.......1553 Woodward Ave., Detroit 48226
Miller, Myron H. (L).............27330 Southfield Rd., Lathrup Village 48075
Miller, Oscar W............Fleetwood Plt. Fbd., G.M.C., Detroit 48209
Miller, Thos. H...1305 Dav. Whitney Bldg., Detroit 48226
Miller, Wm. E. (L).........10 Peterboro, Detroit 48201
Miller, William J.....5649 Inkster Rd., Garden City 48135
Mills, Clinton C...16190 Jas. Couzens Hwy., Detroit 48221
Mills, Geo. R........8209 Allen Road, Allen Park 48101
Milton, Samuel B.................26560 W. Outer Dr., Lincoln Park 48146
Min, Byong G....................23312 Masonic Blvd., St. Clair Shores 48082
Mines, Robert E., Jr. (M)........8401 Woodward Ave., Detroit 48202
Mintz, Edward I.........954 Fisher Bldg., Detroit 48202
Mintz, Morris J..........17563 Greenfield, Detroit 48235
Minui, Morteza..1576 Kirkway Dr., Bloomfield Hills 48013
Mishelevich, Sophie (L).........4651 E. Nine Mile Rd., Warren 48091
Miskinis, Martyna.....393 W. Grand Blvd., Detroit 48216
Missavage, Edward, Jr...........Wayne Co. Genl. Hosp., Eloise 48132
Mitchell, A. W..............12000 Visger, Detroit 48217
Mitchell, C. Leslie......Henry Ford Hosp., Detroit 48202
Mitchell, Darnell P...8401 Woodward Ave., Detroit 48202
Mitchell, Oscar C.......2033 E. Davison, Detroit 48212
Mitchell, Roy A.......1992 Ardmore Rd., Trenton 48183
Mitri, Moufid.............VA Hospital, Dearborn 48121
Moehlig, Robt. C. (L)............3001 W. Grand Blvd., Detroit 48202
Moghissi, Kamran S...............502 Professional Plaza, 3800 Woodward Ave., Detroit 48201
Mogill, Geo..........3150 Second Blvd., Detroit 48201
Moisides, Vasil P. (L)..28 W. Adams Ave., Detroit 48226
Molitz, Howard (A)..............Ophthalmology Dept., Detroit General Hosp., Detroit 48226
Moll, Clarence D. (L)....10 Peterboro St., Detroit 48201
Molner, Jos. G.....14890 Glastonbury Rd., Detroit 48223
Momcilovich, Boxidar............2241 Huron River Dr., Rockwood 48173
Mond, Edward...........10 Witherell St., Detroit 48226
Monge-St. Laurent, E............23607 Farmington Rd., Farmington 48024
Monson, Robt. C...........17520 Chester, Detroit 48224
Montante, Jos R...................3040 Middlebelt Rd., Orchard Lake 48033
Montenegro, Milton.......18512 Hillcrest, Livonia 48152
Montgomery, Wm. C.................26711 Woodward, Huntington Woods 48070
Monto, Raymond W.....Henry Ford Hosp., Detroit 48202
Moore, John W., Jr....8251 W. 8 Mile Rd., Detroit 48221
Moore, Warren R.....17800 E. 8 Mile Rd., Detroit 48236
Moore, Wesley P............Wayne County Gen. Hosp., Eloise 48132
Mopper, Coleman..14633 E. Seven Mile Rd., Detroit 48205
Morales, Miriam V.................402 Deerfield Lane, St. Matthews, Ky. 40207
Moran, Frank J.........16311 Middlebelt, Livonia 48154
Morand, Louis J. (A)......18944 Fairfield, Detroit 48221
Morgan, Donald N...............17800 E. 8 Mile Rd., Harper Woods 48236
Morgan, Philip J...1575 Cherboneau, A 53, Detroit 48207
Moriarty, Geo. J.....3011 W. Grand Blvd., Detroit 48202
Morita, Yoshikazu 3535 W. 13 Mile Rd., Royal Oak 48072
Morley, Arthur R.....15753 Promenade, Allen Park 48101
Morley, George M.....12922 W. Warren, Dearborn 48126
Morley, Harold V.........970 Fisher Bldg., Detroit 48202
Morley, James A. (L)............10514 Plymouth Ave., Detroit 48204
Morley, Thomas S.........4160 John R St., Detroit 48201
Moroun, Sheffick J............675 Parker, Detroit 48214
Morris, Harold L. (L)..........26111 Meadowbrook Rd., Novi 48050
Morrison, George W............2033 Park, Detroit 48226
Morse, William H......19203 Grand River, Detroit 48223
Morton, David G.........19445 Plymouth, Detroit 48228
Moseley, Fredk. L........2561 S. Schaefer, Detroit 48217
Mosen, Max M. (A)..................26116 York Rd., Huntington Woods 48070
Moser, Peter F...............26082 E. Huron River Dr., Flat Rock 48134
Moses, John W...Mt. Carmel Mercy Hosp., Detroit 48235
Moss, Ervin B. (A).......23295 Kipling, Oak Park 48237
Moss, Nathan H...........2847 Trumbull, Detroit 48216
Moss, Norman D...............25919 Meadowlane Dr., Southfield 48075
Moss, Selma S........20905 Greenfield, Southfield 48075
Mott, Carlin P. (L)..2395 W. Grand Blvd., Detroit 48208
Moynihan, John W...2841 Monroe Blvd., Dearborn 48124
Mozen, Herschel E.....300 W. McNichols, Detroit 48203
Mucasey, John......22341 W. 8 Mile Rd., Detroit 48219
Mulero, Hector L.................15101 Southfield Rd., Allen Park 48101
Mullen, Jos. R........19003 Ecorse Rd., Allen Park 48101
Munecas, Rene A...........1554 Tuxedo, Detroit 48206
Munson, Henry T........7815 E. Jefferson, Detroit 48214
Murphy, Scipio G....8401 Woodward Ave., Detroit 48202
Murray, Gordon M.........9901 Whittier, Detroit 48224
Murray, Ian H. L.........474 Fisher Bldg., Detroit 48202
Murray, Robt. J..........3700 West Rd., Trenton 48183
Murray, Thomas H.....25239 Southfield, Southfield 48075
Muske, Paul H........13244 W. Warren, Dearborn 48126
Mutlu, Kadri K......35337 West Warren, Westland 48184
Myers, Danl. W.........1150 Bedford Rd., Detroit 48230
Myers, Steven A.........951 E. Lafayette, Detroit 48207
Nahigian, Russell...17371 Annchester Ave., Detroit 48219
Nahoum, Antoine........1030 Kensington, Detroit 48230
Nash, Edward B.........4075 Inkster Rd., Inkster 48141
Naud, Joseph H...412 Dav. Whitney Bldg., Detroit 48226
Navalta, Dominador G..14868 Reeck St., Southgate 48192
Navori, Cornelius A...3516 Fort Street, Lincoln Park 48146
Naylor, Arthur (L)............2100 N. Tipsico Lk. Rd., Milford 48042
Neeb, Walter G.......16840 E. Warren St., Detroit 48224

Nehra, John M.............17800 E. 8 Mile Rd., #412, Grosse Pointe 48236
Neill, Edwin J..............5026 Bedford, Detroit 48224
Nelson, Darwin M...........63 Ridge Rd., Detroit 48236
Nelson, Harry M. (L) 3001 W. Grand Blvd., Detroit 48202
Nelson, Norman A.........Wayne County Genl. Hosp., Eloise 48132
Nelson, Victor E.......3025 Crooks Rd., Royal Oak 48073
Nesbit, Warren S..........24382 Ross Ct., Detroit 48239
Neufeld, Paul N.............17000 W. Eight Mile Rd., Southfield 48075
Newman, Ernest (R)..17371 Evergreen St., Detroit 48219
Newman, Geo. F.....2012 Monroe Blvd., Dearborn 48124
Newman, Max K....16861 Wyoming Ave., Detroit 48221
Newton, Kenneth......11841 Susan Ave., Warren 48093
Newton, Nicholas (A)......15252 Gratiot, Detroit 48205
Nichols, Wallace, Jr.........2387 Ashby, Trenton 48183
Nickel, Warren O..........861 Monroe, Dearborn 48124
Nickels, Albert W..3535 W. 13 Mile Rd., Royal Oak 48072
Nielsen, Aage E.........3790 Woodward, Detroit 48201
Nielsen, Donald R...............26339 Woodward Ave., Huntington Woods 48070
Nigro, Norman D.......7815 E. Jefferson, Detroit 48214
Nill, John B. (L)........15001 E. Warren, Detroit 48224
Nill, Wm. F. (L)........15001 E. Warren, Detroit 48224
Nino, Luis A...25638 Chapelweigh Dr., Farmington 48024
Noble, Wm. C..........4045 W. Jefferson, Ecorse 48229
Nolan, Bernard E.....5460 Schaefer Rd., Dearborn 48126
Nolting, Wilfred S. H............15850 E. Warren Ave., Detroit 48224
Northcross, David C...2929 W. Boston Blvd., Detroit 48206
Norton, Arthur B. (L)..1077 Fisher Bldg., Detroit 48202
Norton, Martin L....1400 Chrysler Expwy., Detroit 48207
Noshay, Wm. C......2799 W. Grand Blvd., Detroit 48202
Novy, Robt. L. (L)......858 Fisher Bldg., Detroit 48202
Nowicki, Kenneth M......Harper Hospital, Detroit 48201
Nowosielski, P. F...1305 Berkshire, Grosse Pte. Park, 48230
Nwokedi, C.............12000 Visger Rd., Detroit 48217
Nyboer, Jan.............Harper Hospital, Detroit 48201
Nyboer, Victor J.........261 Mack Blvd., Detroit 48201
O'Brien, Geo. M...18239 W. Seven Mile Rd., Detroit 48219
O'Bushkevich, Leon S...15720 W. Warren, Detroit 48228
O'Connor, Katheryn L...17711 Schoolcraft, Detroit 48227
O'Donnell, Dayton H.....22000 Greenfield, Detroit 48237
O'Donnell, Eugene P...2615 W. Jefferson, Trenton 48183
O'Donnell, Kevin T.....15901 W. Nine Mile Rd., #514, Southfield 48075
Oetting, Edward M.....1041 Whittier, Grosse Pte., 48236
O'Gawa, Gilbert M...Henry Ford Hospital, Detroit 48202
Ohmart, Galen B. (L)...........8721 E. Jefferson Ave., Detroit 48214
Ohorodnik, Julius M...Bon Secours Hospital, Detroit 48230
Okun, Milton H.....3261 Sherbourne Rd., Detroit 48221
Oldford, Joseph R...17000 W. 8 Mile Rd., Southfield 48075
Olejniczak, Stanley..........Wayne County Gen Hosp., Eloise 48132
Olen, Alex............13100 Harper Ave., Detroit 48213
O'Linn, Francis P.......1055 Fisher Bldg., Detroit 48202
Olmsted, Geo. S...27305 Southfield, Lathrup Village 48075
Olson, Avis M.....Mt. Carmel Mercy Hosp., Detroit 48235
Olson, Donald T...17701 W. McNichols Rd., Detroit 48235
Olson, George P...........Chrysler Corp., Detroit 48235
Olson, James A...17000 West 8 Mile Rd., Southfield 48075
Olsztyn, Stanley R.........18326 Muirland, Detroit 48221
Oppenheim, Jos. M.........24091 Dante, Oak Park 48237
Ormond, Robt. S.....2799 W. Grand Blvd., Detroit 48202
O'Rourke, Paul V. (A)....2635 Woodstock, Detroit 48203
O'Rourke, Randall M.........7384 12th St., Detroit 48206
Ortiz, Armando............15901 W. 9 Mile Rd., #200, Southfield 48075
Ortiz, Eduardo (A)..Henry Ford Hospital, Detroit 48202
Osius, Eugene A. (L)..........901 Dav. Whitney Bldg., Detroit 48226
Ostrowski, Arthur Z..........610 Northland Med. Bldg., Southfield 48075
Otlewski, Eugene A..............15901 W. 9 Mile Rd., Southfield 48075
Ottaway, John P.....................18226 Mack Ave., Grosse Pte. Farms 48236
Otto, Donald.....Det. Memorial Hospital, Detroit 48226
Owen, Clarence I. (L).................2689 Dupont, Jacksonville, Fl. 32217
Oz, Mustafa C...Wayne County Genl. Hosp., Eloise 48132
Palmer, Alice E...810 Dav. Whitney Bldg., Detroit 48226
Palmer, Milton R.......8700 Dexter Blvd., Detroit 48206
Palmer, Peter..........15830 Fort St., Southgate 48192
Palmisano, I. J........25447 Plymouth Rd., Detroit 48239
Panczak, Tamara..Plymouth State Hosp., Northville 48167
Panic, Stephen M.....1001 W. Seven Mile, Detroit 48203
Pantos, Theo. G...1536 Dav. Whitney Bldg., Detroit 48226
Parfanowycz, S. N. (A)....3347 Grant St., Detroit 48212
Parker, Benj. R...19149 W. Seven Mile Rd., Detroit 48219
Parnell, John W....................21 Whitcomb Dr., Grosse Pte. Farms 48236
Parr, Robt. W. (A)..1126 Audubon Rd., Grosse Pte. 48230
Parrish, Rufus H. (A).....2610 Sturtevant, Detroit 48206
Pasternacki, N. T..........6203 Chene St., Detroit 48211
Pastorius, Melvin K.......22835 Wilson, Dearborn 48128
Patton, Roy B..........Henry Ford Hosp., Detroit 48202
Paul, Lloyd J............19321 Greenfield, Detroit 48235
Pawlowski, Jerome I. (L)..........2009 E. Grand Blvd., Detroit 48211
Payne, Eugene H. (R)..............General Delivery, Bonita Springs, Fl. 33923
Payne, Walter A., Jr.....283 Hillcrest, Grosse Pointe 48236
Paysner, Harry A...............13700 Woodward Ave., Highland Park 48203
Pearce, Arthur J......26491 Carol, Franklin Village 48025
Pearlman, Jack..25860 Concord, Huntington Woods 48070
Pearse, Harry A. (L)............17000 W. Eight Mile, Southfield 48075
Pedersen, Herbert E....3815 Pelham Rd., Dearborn 48124
Peggs, Geo. F.........5419 Livernois Ave., Detroit 48210
Peisojovich, M. (A)........Grace Hospital, Detroit 48201
Pendy, Geo. V...1001 Dav. Whitney Bldg., Detroit 48226
Pendy, John M....1001 David Whitney Bl., Detroit 48226
Penner, David A.......18530 Grand River, Detroit 48223
Pensler, Meyer.....10151 Michigan Ave., Dearborn 48126
Percy, Donald F.....15901 Greenfield Ave., Detroit 48227
Perdue, Grace M.....3011 W. Grand Blvd., Detroit 48202
Perez-Borja, Carlos......951 E. Lafayette, Detroit 48207
Perez-Gurri, Jose L.......3150 Carpenter, Detroit 48212
Perez-Teran, Rene........3033 Carpenter, Detroit 48212
Perkin, Frank S.....3011 W. Grand Blvd., Detroit 48202
Perlis, Hyman L. (L).......10 Peterboro, Detroit 48201
Perlis, Marvin S.......1030 Fisher Bldg., Detroit 48202
Perry, Harold...............Sinai Hosp., Detroit 48235
Perry, Joseph H......259 Lewiston Rd., Grosse Pte. 48236
Petermann, Claus....21421 Kelly Rd., East Detroit 48021
Peters, Wm. R.....12400 E. Seven Mile Rd., Detroit 48205
Peterson, Gustav.............Fisher Body, Willow Run, Ypsilanti 48197
Peterson, Robert A.....18700 Meyers Rd., Detroit 48235
Petoskey, Edward A.........5656 W. Fort, Detroit 48209
Petrick, Thos. J.......15101 Southfield, Allen Park 48101
Petrini, Mario A.........1080 Fisher Bldg., Detroit 48202
Petrucco, Louis A...........14044 W. McNichols Rd., Detroit 48235
Petty, Thos. A...17300 E. Jefferson Ave., Grosse Pte. 48236
Petz, Arthur John....36000 Five Mile Rd., Livonia 48154
Petz, Thomas J...1139 Dav. Whitney Bldg., Detroit 48226
Peven, Philip S.........18709 Meyers Rd., Detroit 48235
Phillips, Burton E...........5050 Joy Rd., Detroit 48204
Picard, Jos. D.......5237 Oakman Blvd., Dearborn 48126
Piccone, Louisa I.......17700 W. Warren, Detroit 48228
Pichette, J. Walton..6650 Greenfield Rd., Dearborn 48126
Pickard, Orlando W. (L)..........14300 W. McNichols, Detroit 48235
Pickering, L. M.........15830 Fort St., Southgate 48192
Pierce, James M., Jr...Wayne St. University, Detroit 48202
Pietra, A. W. (L).....1176 Bishop, Grosse Pointe 48230
Piggott, Leonard R.......951 E. Lafayette, Detroit 48207
Piligian, John T...........3825 Brush St., Detroit 48201
Pingel, James F..........998 Norfolk, Birmingham 48009
Pink, Rose M.......11413 Joseph Campau, Detroit 48212
Pino, Ralph H. (L)...........48151 W. Ann Arbor Rd., Plymouth 48170
Piper, Ralph R...........1495 McKinstry, Detroit 48209
Pittman, John E. (L)............1553 Woodward Ave., Detroit 48226
Pitts, Kenneth E........600 Middlesex, Grosse Pte. 48236

Platz, Carol K.....612 Est. Cen. Prof. Bldg., Detroit 48236
Plavnick, Herman M.........13300 Fenkell, Detroit 48227
Pliskow, Harold.............15901 W. 9 Mile Rd., #202, Southfield 48075
Plotnick, Harold..........18654 Muirland, Detroit 48221
Plous, Eugene I..........569 Fisher Bldg., Detroit 48202
Podolsky, Harold M.......3755 Fort, Lincoln Park 48146
Pogrebniak, A.........25210 Grand River, Detroit 48240
Poim, Senta V...........1069 Fisher Bldg., Detroit 48202
Polentz, Chas. P.....31815 Southfield, Birmingham 48009
Polk, John E...............8721 12th St., Detroit 48206
Pollack, Jerome L.....14551 Southfield, Allen Park 48101
Pollack, John J.....15901 W. 9 Mile Rd., Southfield 48075
Pollard, R. J..................Grace Hosp., Detroit 48201
Pollens, Louis S...12730 W. McNichols Rd., Detroit 48235
Pollina, Clement J...21503 Harper, St. Clair Shores 48080
Ponka, Jos. L.........2799 W. Grand Blvd., Detroit 48202
Pool, Walter D.........20901 Moross Rd., Detroit 48236
Pope, Gerald........Henry Ford Hospital, Detroit 48202
Porretta, Chas. A.............507 Northland Med. Bldg., Southfield 48075
Porretta, Francis S................18591 Saratoga Blvd., Lathrup Village 48075
Porretta, George F.....20905 Greenfield, Southfield 48075
Porter, Fredk. G.........29590 Five Mile, Livonia 48154
Porter, Howard J. (A)...................2555 S.E. 7th, Pompano Beach, Fl. 33062
Portnoy, Harry.........24710 Sussex Ave., Detroit 48237
Posch, Jos. L............1410 Kales Bldg., Detroit 48226
Posner, Irving........18111 Muirland Ave., Detroit 48235
Postigo, Julio C.......275 W. Grand Blvd., Detroit 48216
Potts, Elihue B................7404 Dexter, Detroit 48206
Potts, Maurice B. (A)........Grace Hosp., Detroit 48201
Powaser, Joseph T...................26904 Wilson Dr., Dearborn Heights 48127
Poznanski, Andrew K............Univ. Hosp. Radiology, Ann Arbor 48104
Pracher, John R........3815 Pelham Rd., Dearborn 48124
Prasad, Ananda S...Wayne State University, Detroit 48207
Prasad, Prem S....41001 W. 7 Mile Rd., Northville 48167
Pratt, Jean P. (L)....18910 Fairway Dr., Detroit 48221
Pratt, Lawrence A. (A)............U.S. A.I.D. P.H. E., A.P.O. 96243, San Francisco, Ca.
Preston, Ruth E.....3011 W. Grand Blvd., Detroit 48202
Price, A. Hazen (L)..18605 Birchcrest Ave., Detroit 48221
Price, Alvin E.......1553 Woodward Ave., Detroit 48226
Price, Scott K...........Oakwood Hosp., Dearborn 48124
Priest, Robt. J..........Henry Ford Hosp., Detroit 48202
Prince, Addison E............8942 Dexter, Detroit 48206
Prisbe, Edward J.....16603 Plymouth Rd., Detroit 48227
Priver, Julien..........6741 W. Outer Dr., Detroit 48235
Procailo, Alexander B...29901 Ford Rd., Garden City 48135
Proctor, J. Laurence (A)..............5935 Middlesex, Dearborn 48126
Proctor, Leonard R.....3815 Pelham Rd., Dearborn 48124
Proctor, Lorne D.......Henry Ford Hosp., Detroit 48202
Prokop, Frank P....12740 S. Marrow St., Dearborn 48126
Prokopowycz, V............19666 Conant, Detroit 48234
Proskey, Aloysius J. (A)............16167 Glastonbury, Detroit 48219
Proud, Russel F...26151 Huron River Dr., Flat Rock 48134
Prus, A. Michael......4160 John R Street, Detroit 48201
Prust, Frank W..............1536 David Whitney Bldg., Detroit 48226
Prystowsky, S...............1800 Tuxedo, Detroit 48206
Przybylski, Thom. J.......770 Fisher Bldg., Detroit 48202
Pugel, Andre,............VA Hospital, Allen Park 48101
Pugel, Josephine..Detroit Memorial Hosp., Detroit 48226
Pugh, Howard C.....1553 Woodward Ave., Detroit 48226
Pugliesi, Angelo........9489 E. Outer Dr., Detroit 48213
Pugliesi, Benedetto (L)..9489 E. Outer Dr., Detroit 48213
Purcell, Frank H. (L)....10 Witherell St., Detroit 48226
Puro, Henry E..........1733 Trenton Dr., Trenton 48183
Pursel, Stewart E........1016 Prof. Plaza, Detroit 48201
Purves, W. L.............17595 Parkside, Detroit 48221
Quigley, Eugene H.....................635 N. Gulley, Dearborn Hghts. 48127
Quigley, Wm. G.........1075 Fisher Bldg., Detroit 48202
Quinn, Edward L......1141 Golfview, Birmingham 48009
Quinones, Rafael E.......17200 E. Warren, Detroit 48224

Rabinovitch, Bella M..............26590 Wellington Dr., Franklin 48025
Raby, Naim M.............15830 Fort, Southgate 48192
Rachmaninoff, N...........Harper Hosp., Detroit 48201
Radgens, Paul D.........751 S. Military, Dearborn 48124
Ragheb, Samir...........4407 Roemer, Dearborn 48126
Rahm, Lambert P...14411 E. Jefferson Ave., Detroit 48215
Raiford, Frank P., Jr.........9107 12th St., Detroit 48206
Raikes, James A..........6309 Charlevoix, Detroit 48207
Ralyea, Imbi.......22700 Garrison 1103, Dearborn 48124
Ramos, Herminio R.......9801 Conant, Hamtramck 48212
Ramsey, Robt. H...........3815 Pelham, Dearborn 48124
Randall, David S.......3955 Fort St., Lincoln Park 48146
Rapoport, Bernard..........1800 Tuxedo, Detroit 48206
Rapp, Seymour L...22711 Wrexford Dr., Southfield 48075
Rasimas, Carl A.........1210 Kales Bldg., Detroit 48226
Raskin, Herbert A.....18510 Meyers Road, Detroit 48235
Rastello, Peter B. (R)............3295 West Shore Dr., Orchard Lake 48033
Rattner, Wm. H...1355 Dav. Whitney Bldg., Detroit 48226
Rau, Fredk. W......3790 Woodward Ave., Detroit 48201
Raven, Clara............400 E. Lafayette, Detroit 48226
Ravin, Herbert A.......6767 W. Outer Dr., Detroit 48235
Ravitz, Louis A........23350 Thorncliff, Southfield 48075
Ray, Kenneth J........28059 Elba Dr., Grosse Ile. 48138
Raynor, Harold F. (L)....49 Virginia Pk., Detroit 48202
Razi, Massoud............1214 S. Wayne, Wayne 48184
Rebandt, Raymond W...2615 W. Jefferson, Trenton 48183
Rebuck, John W.....2799 W. Grand Blvd., Detroit 48202
Redding, Foster K...Henry Ford Hospital, Detroit 48202
Redding, Lowell G.................1336 Southfield Rd., Lincoln Park 48146
Reder, Benjamin..17301 W. Eight Mile Rd., Detroit 48235
Redfern, W. Earl....2799 W. Grand Blvd., Detroit 48202
Reed, Ivor E. (L)............25579 Loch Lomond Dr., Dearborn 48125
Reed, Joseph O., Jr...........448 Lincoln, Detroit 48230
Reed, Melvin L...........4160 John R St., Detroit 48201
Rees, Howard C. (L)....15700 Mack Ave., Detroit 48224
Reese, James R.........Ford Motor Co., Dearborn 48127
Reichert, Carl E...18412 Mack Avenue, Grosse Pte. 48236
Reid, John G........1553 Woodward Ave., Detroit 48226
Reid, Wesley G...34186 Sprg. Valley Dr., Westland 48185
Reidt, William U............1800 Tuxedo, Detroit 48206
Reiff, Morris V.............10241 Joy Rd., Detroit 48204
Reinhard, Richard E.............7815 E. Jefferson Ave., Detroit 48214
Reinsh, Ernest R...600 Trailwood Path, Birmingham 48010
Reisig, Robert O.............20867 Mack, Detroit 48236
Reisman, Saml. G.....1553 Woodward Ave., Detroit 48226
Reive, David L. E. (A)...25447 Plymouth, Detroit 48239
Remski, James E........29447 Ravine Dr., Livonia 48152
Reno, George L..........970 Fisher Bldg., Detroit 48202
Rentenbach, Robt. F..........314 David Whitney Bldg., Detroit 48226
Resto, Manuel.........21955 Wildwood, Dearborn 48128
Resto Soto, A. D........17644 W. Warren, Detroit 48228
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Schmidt, Harry E........667 Fisher Bldg., Detroit 48202
Schmidt, Johann........7815 E. Jefferson, Detroit 48214
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Stellhorn, Mary C. (A)..16616 Mack Ave., Detroit 48224
Stempel, Edward M...18324 Fairfield Ave., Detroit 48221
Sterba, Richard F....18228 Mack Ave., Grosse Pte. 48236
Stern, Edward A.............12700 W. Seven Mile Rd., Detroit 48235
Stern, Joseph W...15901 W. 9 Mile Rd., Southfield 48075

Stern, Julian....15121 W. McNichols Rd., Detroit 48235
Stern, Leonard H.........19200 Aften Rd., Detroit 48203
Stern, Louis D. (L)..1553 Woodward Ave., Detroit 48226
Sternhill, Vernon.............1800 Tuxedo, Detroit 48206
Stevens, Chas. H...15901 W. 9 Mile Rd., Southfield 48075
Stevenson, Chas. S........960 Fisher Bldg., Detroit 48202
Stevenson, Lee B.......Henry Ford Hosp., Detroit 48202
Stewart, Maitland N., Jr..............20905 Greenfield, Southfield 48075
Stewart, Marjorie (A).....581 Golfcrest, Dearborn 48124
Stewart, Robert M......10933 Farmington, Livonia 48150
Stiefel, Danl. M. (L)..........1563 Dav. Whitney Bldg., Detroit 48226
Stillwater, Karl.........18221 Pennington, Detroit 48221
Stith, Dwight E............505 Owen St., Detroit 48202
Stobbe, Godfrey D...........Grace Hosp., Detroit 48201
Stock, Thomas B.....25500 Friar Lane, Southfield 48075
Stocker, Lawrence L...7310 W. 7 Mile Rd., Detroit 48221
Stocker, Marvin L.....16401 Grand River, Detroit 48227
Stockwell, Benj. W...1553 Woodward Ave., Detroit 48226
Stokfisz, Thaddeus........7012 Michigan, Detroit 48210
Stoller, Raymond..25210 Grand River Ave., Detroit 48240
Stone, Sidney L.....22790 Kelly Rd., East Detroit 48021
Stoyka, Michael R........1977 Oxford, Grosse Pte. 48236
Straith, Richard E...2605 W. Grand Blvd., Detroit 48208
Strand, Martin E....................22400 Cherry Hill, West Dearborn 48124
Stratton, Peter K.........5237 Oakman, Dearborn 48128
Strauss, Ernest G.......................67 Sunningdale, Grosse Pte. Shores 48236
Stricker, Henry D. (L)..........930 Weaver Rd., R#2, Milford 48042
Strickler, D. T., Jr. 22231 W. Outer Drive, Dearborn 48124
Strickroot, Fred L........3800 Bishop Rd., Detroit 48224
Stronski, G. E.............9901 Whittier, Detroit 48224
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Stryker, Walter A........P. O. Box 31, Wyandotte 48192
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Stubbs, Harold W. (L)..........13930 Woodward Ave., Highland Park 48203
Subrin, Mayer..4430 Quarton Rd., Bloomfield Hills 48013
Sudakin, Leonard....10326 W. 7 Mile Rd., Detroit 48221
Suen, Irene T. S...Chrysler Corp., Box 1919, Detroit 48231
Sugar, H. Saul..........970 Fisher Bldg., Detroit 48202
Sugarman, Marcus H...15201 W. McNichols, Detroit 48235
Sugayan, Norberto A...34275 Munger Dr., Livonia 48154
Sullivan, Paul J.....................26711 Woodward, Huntington Woods 48070
Sullivan, Thomas M......951 E. Lafayette, Detroit 48207
Sultzman, L. Carl..55 Vendome, Grosse Pte. Farms 48236
Sumead, Bernard T...2021 Monroe Blvd., Dearborn 48124
Summers, Wm. A.....1553 Woodward Ave., Detroit 48226
Sutherland, Jacob M. (L)........8900 E. Jefferson Ave., Detroit 48214
Suwinski, Raymond H..................9801 Conant St., Hamtramck 48212
Swan, Donald C.............17000 W. Eight Mile Rd., Southfield 48075
Swan, Lionel F...............9245 Mack, Detroit 48214
Swanson, Carl W............936 Alter Rd., Detroit 48215
Swanson, Robt. G.............314 Eastland Prof. Bldg., Detroit 48236
Swartz, Fred G., Jr...........1329 Dav. Whitney Bldg., Detroit 48226
Sweeny, Donald N., Jr.....8445 E. Jefferson, Detroit 48214
Switzer, Bertrand C. (R)..............1862 Riverside, Columbus, Oh. 43212
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Szokolay, Joseph P.....Henry Ford Hosp., Detroit 48202
Taber, Rodman E.......Henry Ford Hosp., Detroit 48202
Tactac, Albert J.........15240 Merriman, Livonia 48154
Tadian, Joella G.......23100 Cherryhill, Dearborn 48124
Tagett, John P...25750 W. Outer Dr., Lincoln Park 48146
Talbot, Frank G..............1365 Cass, Detroit 48226
Tallant, Edward J........18041 Greenfield, Detroit 48235
Talley, Robt. W.........Henry Ford Hosp., Detroit 48202
Talmers, Fredk. N.........V.A. Hospital, Dearborn 48121
Tamblyn, E. J. (L).....737 Marlborough, Detroit 48215
Tan, Liong G..............888 Chalmers, Detroit 48215
Tanay, Emanuel.........861 Fisher Bldg., Detroit 48202
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Tarpinian, Harry...10955 Farmington Rd., Livonia 48150
Tasker, Helen E.......76 W. Adams Ave., Detroit 48226
Tassie, Ralph N. (L)..15000 Gratiot Ave., Detroit 48205
Tatelis, Gabriel A...21811 Kelly Road, East Detroit 48021
Tatelman, Maurice..6767 W. Outer Drive, Detroit 48235
Taurence, Wm. H.....1860 Ford Ave., Wyandotte 48192
Tavlan, Cemalettin....Annapolis Hospital, Wayne 48184
Taylor, Amos, III...........301 E. Kirby, Detroit 48202
Taylor, Junius L.....1566 W. Grand Blvd., Detroit 48208
Taylor, Miles.......550 Estld. Prof. Bldg., Detroit 48236
Taylor, Nelson M...215 Dean Lane, Grosse Pte. Park 48236
Taylor, Richard A.......28 W. Adams St., Detroit 48226
Taylor, Ward M.....2201 E. Jefferson Ave., Detroit 48207
Taylor, Wm. V.........17200 E. Warren, Detroit 48224
Tazzioli, Henry A.......21970 Moross Rd., Detroit 48236
Tear, Malcolm J. J...862 W. McNichols Rd., Detroit 48203
Teitelbaum, Myer....18510 Meyers Road, Detroit 48235
Tellez, Henry (A)..........Wayne St. Univ. Hosp. Tng., Detroit 48207
Telmos, Allen J...16401 Grand River Ave., Detroit 48227
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Teves, Manuel L.............13020 Mack, Detroit 48215
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Theodoulou, Glaucos........1800 Tuxedo, Detroit 48206
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Thomas, L. Murray............801 Dav. Whitney Bldg., Detroit 48226
Thompson, Arthur L.........12632 Dexter, Detroit 48238
Thompson, Hugh O.....6014 W. Fort St., Detroit 48209
Thompson, Wm. A. (R)....12632 Dexter, Detroit 48238
Thomson, Danl. C.....2934 Biddle Ave., Wyandotte 48192
Thornton, Jerry A..........525 Visger Rd., Ecorse 48229
Thosteson, G. C...1139 Dav. Whitney Bldg., Detroit 48226
Thumann, Robt. C...................20045 Mack Ave., Grosse Pte. Woods 48236
Thumin, Sadie............15306 Joy Rd., Detroit 48228
Timma, Richard J............17220 W. Eight Mile Rd., Southfield 48075
Ting, Sik Woo.........Oakwood Hosp., Dearborn 48124
Ting, Yeeh Ming....29555 Bristol Rd., Birmingham 48010
Toal, Robert E.........20953 Grand River, Detroit 48219
Tobar, Rodrigo R.....21110 Winchester, Southfield 48075
Todoroff, Theodore G...22146 Ford Rd., Dearborn 48128
Tolbert, Jesse C.....8401 Woodward Ave., Detroit 48202
Tolbert, Vassal G.............3461 W. C. Chrysler Exp., Detroit 48201
Torres, Estelle P.........3985 Caniff, Hamtramck, 48212
Torres, Raul M., Jr.....3985 Caniff St., Hamtramck 48212
Tourkow, Lawrence P.............3290 Sherbourne Rd., Detroit 48221
Townsend, Frank M. Jr., (L)............1055 Trumbull, Detroit 48216
Tracey, John M.......15317 W. McNichols, Detroit 48235
Tracy, Edward G.........3411 Evaline St., Detroit 48212
Treisman, E. J...15105 W. Seven Mile Rd., Detroit 48235
Tremain, Harold L.........15475 Ashton, Detroit 48223
Triska, Franz K.....18750 Woodward Ave., Detroit 48203
Troester, Geo. A.............81 E. Kirby, Detroit 48202
Trotsky, Martin B........7411 Third Ave., Detroit 48202
Truba, Paul K.......22770 Kelly Rd., East Detroit 48021
Trudeau, John M...........14200 Puritan, Detroit 48221
Trudgen, Paul E.......1224 Beechmont, Dearborn 48124
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Tulloch, John A...................17800 E. 8 Mile Rd., Harper Woods 48236

Tulloch, John C...1040 Dav. Whitney Bldg., Detroit 48226
Tumbokon, R. T.........VA Hospital, Allen Park 48101
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Turner, Edward T........5050 Joy Road, Detroit 48204
Turner, Rachel E......895 W. Oakridge, Ferndale 48220
Turner, Robert R.....2841 Monroe Blvd., Dearborn 48124
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Ujda, Chester J.........32302 Woodbrook, Wayne 48184
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Ulrich, John L.......18550 W. Outer Dr., Dearborn 48128
Ulrich, Willis H...22365 Grand River Ave., Detroit 48219
Underberg, John.........Harper Hospital, Detroit 48201
Unkefer, Wm. T.....17401 Greenfield Rd., Detroit 48235
Usndek, Harold E.......18485 Mack Ave., Detroit 48236
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Vaitas, Otonas.....10531 Farmington Rd., Livonia 48150
Vaitkevicius, V.............4160 John R, Detroit 48201
Valdesuso, R. I.........14763 Rossini Dr., Detroit 48205
Valdez, Jose V.............5450 Fort St., Trenton 48183
Valenzuela, E. Valdes..28382 Harwich, Farmington 48024
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Van Eck, James E......11540 Morang Dr., Detroit 48224
Van Hoek, Donald E....................20323 Mack, Grosse Pte. Woods 48236
Van Raaphorst, L. F........861 Monroe, Dearborn 48214
Van Riper, Steven L.........1490 Iroquois, Detroit 48214
Van Slyck, E. J.........Henry Ford Hosp., Detroit 48202
Vanvalzah, Henry J...........Ford Mtr. Co., Miller Rd., Dearborn 48120
Vardon, Edward M. (L).........12897 Woodward Ave., Highland Park 48203
Vartanian, Hratch......6246 Chase Rd., Dearborn 48126
Vasu, Vasile O. (L)..4829 Woodward Ave., Detroit 48201
Vaughn, Clarence B........Grace Hospital, Detroit 48201
Veling, William F..................13700 Woodward, Highland Park 48203
Vence, Carlos A...17000 West 8 Mile Rd., Southfield 48075
Vera, Ramon W...15901 W. 9 Mile Rd., Southfield 48075
Victor, Jay...........14575 Southfield, Allen Park 48101
Villaflor, Rady I........Childrens Hospital, Detroit 48202
Villani, Patrick A.....20914 Kelly Rd., East Detroit 48021
Villarosa, Isaias S...........Grace Hosp., Detroit 48201
Villarreal, Carlos G......6832 Pinehurst, Dearborn 48126
Vincent, Charles C...........2424 Puritan, Detroit 48238
Vincent, John W.......22146 Ford Rd., Dearborn 48128
Vipond, W. Fraser.....15398 Gratiot Ave., Detroit 48205
Viscomi, Geo. J.........23422 Ford Rd., Dearborn 48128
Visscher, Donald W...12922 W. Warren, Dearborn 48126
Vogel, Lloyd (A)................Ophthalmology Dept., Detroit General Hosp., Detroit 48226
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Vonglahn, Noel A.......19075 Middlebelt, Livonia 48152
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Wagner, John R.........474 Fisher Bldg., Detroit 48202
Wagoner, George F. (M)......14300 W. McNichols Rd., Detroit 48235
Wahl, Richard A. (M)........17555 Jas. Couzens Hwy., Detroit 48235
Wainger, Max J......15105 W. 7 Mile Rd., Detroit 48235
Wainstock, Michael A...........621 David Whitney Bl., Detroit 48226
Wakeman, Everal M....155 S. Denwood, Dearborn 48124
Waldbott, Geo. L. (L)............2930 W. Grand Blvd., Detroit 48202
Walden, Robert E...19318 Wyoming Ave., Detroit 48221
Walker, Frank B., II.................1206 Balfour Rd., Grosse Pte. Park 48230
Walker, Geo. L.....7815 E. Jefferson Ave., Detroit 48214
Walker, Robert M.........2101 Monroe, Dearborn 48124
Walkowiak, Robt. G.....76 W. Adams Ave., Detroit 48226
Wallace, Silas W. (L)..........7815 E. Jefferson Ave., Detroit 48214
Wallaert, Albert A. J...........941 Burns, Detroit 48214
Waller, John P.........32238 Schoolcraft, Livonia 48150
Walt, Alexander J...Detroit Receiving Hosp., Detroit 48226
Walter, Arthur W...7165 Old Mill Rd., Birmingham 48010
Walter, Floyd J....18714 Grand River Ave., Detroit 48223
Wang, Chun Heng H...25500 Edgemont, Southfield 48075
Wang, Joy Ya Hsiang................2020 Middlebelt, Garden City 48135
Warren, Bernice K...24111 Southfield Rd., Southfield 48075
Warren, Irving A...24111 Southfield Rd., Southfield 48075
Warren, Max W...23120 Valley Crest Ln., Southfield 48075
Wass, Richard A......3815 Pelham Rd., Dearborn 48124
Wasserman, Harold..22341 W. Eight Mile, Detroit 48219
Wassermann, Lewis C...........300 W. McNichols Rd., Highland Park 48203
Waszak, Chas. J.....................26111 Woodward, Huntington Woods 48070
Waters, William L.......Burns Clinic, 560 W. Mitchell, Petoskey 49770
Watling, Robert L...15761 Andover Dr., Dearborn 48120
Watson, Harwood G..............935 S. Military Ave., Dearborn 48124
Watson, James E., Jr....18524 Grand River, Detroit 48223
Watts, Fredk. B.........16321 Mack Ave., Detroit 48224
Watts, John C...........7360 12th Street, Detroit 48206
Watts, Jos. C......15901 W. 9 Mile Rd., Southfield 48075
Wayne, Morris A.....15930 Livernois Ave., Detroit 48221
Weaver, Clarence E. (R)..........1260 S.E. Fourth Ct., Deerfield Beach, Fl. 33441
Weaver, Delmar F...........1100 Bishop, Detroit 48230
Weber, Karl W.....18101 E. Warren Ave., Detroit 48224
Webster, Jeremy D.......20045 Mack, Grosse Pte. 48236
Webster, John E. (A)......47 Pine Court, Detroit 48236
Weckstein, Marvin S.............28290 Tavistock Trail, Southfield 48075
Weed, Milton R...................1059 Berkshire Rd., Grosse Pte. Park 48236
Wegryn, Richard S............Detroit Memorial Hosp., Detroit 48226
Wehenkel, Albert M. (L)......3929 Chaucer Pl., 602H, Sarasota, Fl. 33577
Wehr, Maurice B.....2355 Fort St., Lincoln Park 48146
Weidner, John H...25701 Joy Rd., Dearborn Hghts. 48127
Weiksnar, John F...........1800 Tuxedo, Detroit 48206
Weiner, Allen D....22341 W. Eight Mile, Detroit 48219
Weiner, Maurice B.......20211 Greenfield, Detroit 48235
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Weingarten, Charles J.........15121 W. McNichols Rd. Detroit 48235
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Weisberg, Harry..15101 W. McNichols Rd., Detroit 48235
Weisberg, Jacob (A)..........15101 W. McNichols Rd., Detroit 48235
Weisenthal, Irvin I...5764 Woodward Ave., Detroit 48202
Weiss, Casimir P.....10036 Jos. Campau, Detroit 48212
Weiss, Irving R..........25 Pearl St., Galesburg 49053
Weissman, Fredrick...............20905 Greenfield Rd., Southfield 48075
Welch, John H.....18550 W. Outer Dr., Dearborn 48128
Welhaf, William R.....22101 Moross Rd., Detroit 48236
Wells, Herschel J....Wayne Co. Gen. Hosp., Eloise 48132
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West, Howard G...........12739 Puritan, Detroit 48227
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Weston, Bernard......20403 Snowden Ct., Detroit 48235
Weston, Earl E...18101 Jas. Couzens Hwy., Detroit 48235
Weston, Horace L...15901 W. Nine Mile, Southfield 48075
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Whaley, Robert L.......3150 Second Ave., Detroit 48201
Wharton, Thos. V.........1809 Oak St., Wyandotte 48192
Wheatley, Charles E. (A)..4407 Roemer, Dearborn 48126
Wheeler, Stewart C...........18901 W. McNichols Rd., Detroit 48219
Whelan, Jos. L.......28 W. Adams Ave., Detroit 48226
White, Donald H.......20685 Meridian, Grosse Ile 48138
White, Jacob E...........3413 McDougall, Detroit 48207
White, Milton W.......1439 E. Outer Dr., Detroit 48234
White, Prosper D......58 W. Adams Ave., Detroit 48226
White, Theodore M.....7341 W. Warren, Detroit 48210
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Whitehead, Walter K...........17800 E. Eight Mile Rd., Detroit 48236
Whitehouse, Fred W...2799 W. Grand Blvd., Detroit 48202
Whiteley, Robt. K.............608 Estlnd. Cen. Prof. Bl., Detroit 48236
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Wiener, Morton J.........150 Livernois, Ferndale 48220
Wietersen, Fred K......18700 Meyers Rd., Detroit 48235
Wikiera, Edward S......15120 Michigan, Dearborn 48126
Wilcox, Leslie F.....................505 Middlesex Rd., Grosse Pte. Park 48236
Wilhelm, Rudolf E...751 S. Military Rd., Dearborn 48124
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Williams, Earl R...........4407 Roemer, Dearborn 48126
Williams, Eugene W.....6246 Chase Rd., Dearborn 48126
Williams, John H........18633 Mack Ave., Detroit 48236
Williams, Joshua S.......5050 Joy Road, Detroit 48204
Williamson, W. A.....2585 W. Grand Blvd., Detroit 48208
Willis, Robt. L., Jr...........6506 Covington Rd., #316, Ft. Wayne, Ind. 46804
Willoughby, Wm. A......974 Fisher Bldg., Detroit 48202
Wilner, Freeman M...........15001 W. Eight Mile Rd., Detroit 48235
Wilner, Irvin A.....17701 McNichols Rd., Detroit 48235
Wilson, Andrew G.............19203 Grand River Ave., Detroit 48223
Wilson, Francis M.........15439 Harper, Detroit 48224
Wilson, Gerald A. (L)..19203 Grand River, Detroit 48223
Wilson, Gerald S.....3011 W. Grand Blvd., Detroit 48202
Wilson, Ian D.............Burns Clinic Medical Center, Petoskey 49770
Wilson, Merton C......15439 Harper Ave., Detroit 48224
Wilson, Paul H.......901 W. Grand Blvd., Detroit 48208
Wilson, Robert F...Detroit Receiving Hosp., Detroit 48226
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Winkler, Helen H.....14411 E. Jefferson, Detroit 48215
Winnick, Lawrence....13340 W. 7 Mi. Rd., Detroit 48235
Winton, Geo. J.........1150 Griswold St., Detroit 48226
Wise, Robt. K....17640 W. 12 Mile Rd., Southfield 48075
Wishropp, Edward A. (L) 20250 Mack, Grosse Pte. 48236
Withey, Grant J.............7430 Second, Detroit 48202
Wittenberg, Arthur..7101 W. Chicago Blvd., Detroit 48204
Wittenberg, D. H.......1535 E. State Fair, Detroit 48203
Wittenberg, Samson S....18718 Woodward, Detroit 48203
Wittenberg, Sydney S...4400 Livernois Ave., Detroit 48210
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Wolfe, John N...........432 E. Hancock, Detroit 48201
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Wolfram, Bonnie R...620 New Center Bldg., Detroit 48202
Wolfson, Wm. Q..........3000 Seminole, Detroit 48214
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Wood, Kenneth A.........3919 John R St., Detroit 48201
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Woodbury, Ralph F......21223 Mack, Grosse Pte. 48236
Woodley, Bernard J.........3700 West Rd., Trenton 48183
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Woods, Joseph J....2022 Washtenaw Rd., Ypsilanti 48197
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Worrell, Calier H...20250 Mack, Grosse Pte. Woods 48236
Worzniak, Jos. J.....2312 Biddle Ave., Wyandotte 48192
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Wright, Charles H.........50 Westminster, Detroit 48202
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Wyatt, Rudolph A........2785 S. Fort St., Detroit 48217
Wybranowski, Jan......17644 W. Warren, Detroit 48228
Wylie, John H.........Henry Ford Hosp., Detroit 48202
Wylin, Robert...........Harper Hospital, Detroit 48201
Wysocki, Raymond L......2536 Rutledge, Trenton 48183
Yapchai, Rodolfo.1846 Dav. Whitney Bldg., Detroit 48226
Yarjanian, Ara........3815 Pelham Rd., Dearborn 48124
Yarrows, Morton I.......455 Medbury St., Detroit 48202
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Young, David J.....19820 Plymouth Road, Detroit 48228
Young, Donald A.............14807 W. McNichols Rd., Detroit 48235
Young, Donald C. (R)............43875 Nine Mile Rd., Northville 48167
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Young, Richard D.......31500 Schoolcraft, Livonia 48150
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Zako, Louis R..........7720 Allen Rd., Allen Park 48101
Zaleski, Edward J........4520 Firestone, Dearborn 48126
Zane, Alan Irving........7411 Third Ave., Detroit 48202
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Zawacki, Sigmund G.....22146 Ford Rd., Dearborn 48128
Zbikowski, Jos......31500 Schoolcraft Rd., Livonia 48150
Zbikowski, Z. T.....31500 Schoolcraft Rd., Livonia 48150
Zbudowski, Myron R...........10040 Jos. Campau Ave., Detroit 48212
Zelenock, Michael N........15830 Fort, Southgate 48192
Zemaitis, Petras.........33000 Palmer Rd., Wayne 48184
Zemens, Jos. L.......11420 E. 9 Mile Rd., Warren 48089
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Zobl, Eldred......15901 W. 9 Mile Rd., Southfield 48075
Zolliker, Margaret Z.......289 Moross, Grosse Pte. 48236
Zubroff, L. S............760 Fisher Bldg., Detroit 48202
Zuelzer, Wolf W.......5224 St .Antoine St., Detroit 48202
Zukowski, Henry J.......72 N. Deeplands, Detroit 48236
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Michigan State Medical Society

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Wilson, Earl C.	74	24
Wilson, Francis M.	222	78
Wilson, Geo. C.	114	36
Wilson, George M., Jr.	134	39
Wilson, Gerald A.	222	78
Wilson, Gerald S.	222	78
Wilson, Ian D.	222	78
Wilson, J. Leroy	218	56
Wilson, John R.	106	35
Wilson, Merton C.	222	78
Wilson, Norman R.	126	38
Wilson, Paul H.	222	78
Wilson, Paul R.	174	48
Wilson, Robert F.	222	78
Wilson, Robert J.	106	35
Wilson, Thos. G.	22	17
Wilton, Robert E.	74	24
Wimmer, Helmut	222	78
Winfield, Emery D.	106	35
Winfield, Raymond J.	202	51
Winkler, Helen H.	222	78
Winkler, Henry J.	82	25
Winkler, James M.	218	56
Winkler-Prins, V.	174	48
Winnick, Lawrence C.	222	78
Winslow, Sherwood B.	34	19
Winter, Garrett E.	106	35
Winter, John K.	186	49
Winter, Wm. G., Jr.	186	49
Winton, Geo. J.	222	78
Wischman, Charles L.	218	56
Wise, Robert	30	18
Wise, Robt. K.	222	78
Wise, Warren A.	26	18
Wiseman, Bertha A.	10	16
Wishropp, Edward A.	222	78
Wisniewski, E. M.	174	48
Withey, Grant J.	222	78
Witte, David B.	214	52
Wittenberg, Arthur A.	222	78
Wittenberg, D. H.	222	78
Wittenberg, Samson S.	222	78
Wittenberg, Sydney S.	222	78
Witter, Jos. A.	222	78
Wittman, Thomas S.	98	28
Witus, Carl	126	38
Witus, Morris	222	78
Wlodarczyk, A. J.	222	78
Wolcott, Nan D.	62	23
Wolf, Ervin	126	38
Wolf, Marvin B.	114	36
Wolf, Melvyn D.	62	23

Wolfe, John N.	222	78
Wolfe, Kenneth P.	74	24
Wolfe, Max O.	222	78
Wolfe, Warren E.	174	48
Wolfram, Bonnie R.	222	78
Wolfson, William Q.	222	78
Wollum, Arnold	54	20
Wolodzko, Joseph	222	78
Wolter, James G.	222	78
Wolter, J. Reimer	218	56
Wolters, Burton J.	162	41
Womack, Melisande	222	78
Wonacott, Robert G.	70	24
Wood, Alfred L.	222	78
Wood, Cornelius B.	74	24
Wood, Douglas J.	222	78
Wood, John M.	74	24
Wood, Kenneth A.	222	78
Wood, Merle G.	178	48
Wood, Warren A., Jr.	174	48
Wood, Wilford C.	222	78
Woodburne, Harris L.	22	17
Woodburne, R. T.	218	56
Woodbury, Ralph F.	222	78
Woodford, Hackley E.	26	18
Woodhams, William H.	102	30
Woodley, Bernard J.	222	78
Woodring, Albert J.	222	78
Woods, Joseph J.	222	78
Woods, Scott W.	218	56
Woodsides, K. T.	62	23
Woodward, Hanna L.	174	48
Woodward, Robert D.	174	48
Woodworth, Edwin S.	118	36
Woolfenden, Jos. B.	222	78
Woomer, Donald F.	190	50
Worgess, Duane R.	34	19
Work, Walter P.	218	56
Worrell, Calier H.	222	78
Worth, Melissa H. C.	218	56
Worthington, Ralph	90	27
Wortley, Chas. K.	90	27
Worzniak, Jos. J.	222	78
Wreggit, Winston R.	222	78
Wright, Charles H.	222	78
Wright, Edwin M.	190	50
Wright, Geo. W., Jr.	62	23
Wright, Harold L.	218	56
Wright, J. K., Jr.	70	24
Wright, Kenneth C.	134	39
Wright, Thomas B.	22	17
Wright, Thos. B.	106	35
Wu, Clyde Ying Chau	222	78
Wu, Jack F.	102	30
Wunsch, Richard E.	70	24
Wurz, John F.	106	35
Wyatt, Rudolph A.	222	78
Wybranowski, Jan	222	78
Wylie, John H.	222	78
Wylin, Robert	222	78
Wyman, John S.	218	56
Wyngaarden, Martin K.	106	35
Wynn, Geo. H.	114	36
Wysocki, Raymond L.	222	78
Wyte, Wm. C.	126	38
Yamasaki, Ken	126	38
Yang, William G.	102	30
Yannitelli, S. A.	34	19
Yapchai, Rudolfo	222	78
Yaple, Edward L.	102	30
Yared, Jerome A.	106	35
Yarjanian, Ara	222	78
Yaroch, William C.	218	56
Yarrows, Morton I.	222	78
Yates, Arthur J. W.	222	78
Yelin, Frank S.	218	56
Yesayian, H. G.	222	78
Yesko, Veldora C.	174	48
Yff, John H.	186	49
Ylvisaker, John R.	174	48
Yntema, Stuart	190	50
Yobst, G. James	154	40
Yoder, Orus R.	218	56
Yoder, Robt. R.	222	78
Yonkman, Fredk. F.	186	49
Yost, Kenneth W.	194	51
Yost, William G., Jr.	106	35
Yott, Wm. J.	222	78
Youel, David B.	174	48
Young, Arthur R.	174	48
Young, David J.	222	78
Young, Donald A.	222	78
Young, Donald C.	222	78
Young, Donald G.	106	35
Young, Frank A.	222	78
Young, Irving I.	222	78
Young, John	190	50
Young, John Harley	70	24
Young, John R.	34	19
Young, Malcolm C.	162	41
Young, Richard D.	222	78
Young, Viola M.	222	78
Young, Wm. R.	214	52
Youngman, Douglas C.	226	56
Youngs, Cyril A.	102	30
Youngs, John A.	194	51
Youngstrom, Clarence S.	222	78
Younis, Ahmad	94	27
Yudashkin, Ernest G.	222	78
Yull, Arthur B.	194	51
Yun, Bo Sup	206	51
Yuzon, Ricardo A.	174	48
Zabinski, Edward J.	222	78
Zack, Burton J.	222	78
Zadeh, A. T.	222	78
Zadvinskis, Z.	106	35
Zager, Bernard S.	126	38
Zako, Louis R.	222	78
Zaleski, Edward J.	222	78
Zanstra, Benjamin	186	49
Zane, Alan Irving	222	78
Zaplitny, R. B.	34	19
Zaplitny, Sophia	34	19
Zara, Sabah E.	222	78
Zarafonetis, C. J. D.	218	56
Zavela, Dan	126	38
Zavell, Paul M.	222	78
Zawacki, Sigmund G.	222	78
Zbikowski, Jos.	222	78
Zbikowski, Z. T.	222	78
Zbudowski, Myron R.	222	78
Zeis, Myron G.	62	23
Zelenock, Michael N.	222	78
Zelko, Daniel M.	62	23
Zemaitis, Petras	222	78
Zemens, Jos. L.	222	78
Zemmer, H. R.	110	36
Zerbi, Victor M.	218	56
Zettelmaier, John L.	102	30
Zevallos, Carlos	222	78
Zheutlin, Bertram	34	19
Zick, Gerald A.	90	27
Zick, Luther H.	26	18
Ziel, Hermann A., Jr.	90	27
Zielke, Irwin H.	70	24
Ziliak, Alois L., Jr.	22	17
Zimberg, Leslie L.	222	78
Zimmerman, Jos. G.	70	24
Zimmerman, Walter J.	174	48
Zimmerman, Wm. G.	106	35
Zimont, Charles R.	198	51
Zimont, Raymond D.	198	51
Zindler, Geo. A.	34	19
Zink, Robert A.	126	38
Zinn, Geo. H.	222	78
Zinterhofer, J. J., Jr.	174	48
Zipf, Charles	170	42
Zirkin, Richard M.	222	78
Zobl, Eldred	222	78
Zografov, Nikolas S.	174	48
Zolen, Margaret H.	102	30
Zolliker, Carl R.	110	36
Zolliker, Margaret Z.	222	78
Zook, Gilbert E.	126	38
Zotovas, Alex	126	38
Zrull, Joel P.	218	56
Zubroff, Leonard S.	222	78
Zuelzer, Wolf W.	222	78
Zujko, Alphonse J.	174	48
Zukowski, Henry J.	222	79
Zukowski, Sigmund A.	222	79
Zwemer, Rodger J.	106	35
Zwirkoski, Thaddeus S.	222	79
Zylik, Michael K.	222	79

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Paul DeKruif, Ph.D...Wake Robin, Holland, Mich. 49423
Lester P. Dodd............1600 Commonwealth Bldg.,
Detroit, Mich. 48226

Donald E. Johnson..211 E. Court St., Flint, Mich. 48503
E. C. Crosby, Ph.D...................Michigan League,
Ann Arbor, Mich. 48104
Bradley M. Patten, Ph.D...........2126 Highland Road,
Ann Arbor, Mich. 48104
Reuben L. Kahn, DSC................8 Ruthven Place,
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The professional association of Michigan doctors of medicine
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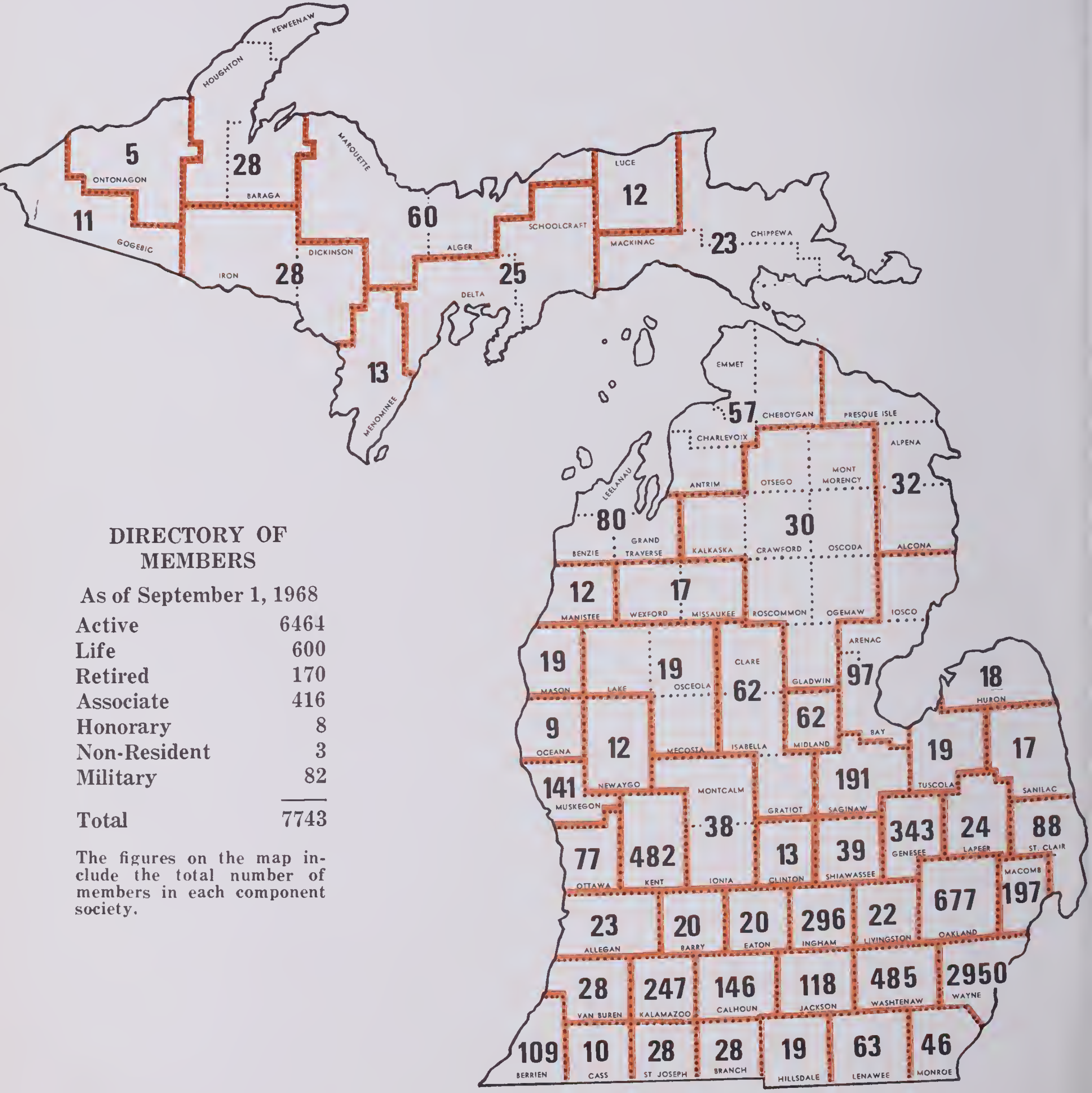
Directory of Members – 1968

The orange lines on the map indicate the boundaries for the component medical societies.


KEWEENAW
HOUGHTON
5
ONTONAGON
28
BARAGA
MARQUETTE
11
GOGEBIC
IRON
28
DICKINSON
60
ALGER
SCHOOLCRAFT
LUCE
12
MACKINAC
23
CHIPPEWA
25
DELTA
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MENOMINEE
EMMET
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CHEBOYGAN
PRESQUE ISLE
CHARLEVOIX
ALPENA
LEELANAU
ANTRIM
OTSEGO
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ALCONA
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WEXFORD
MISSAUKEE
ROSCOMMON
OGEMAW
IOSCO
ARENAC
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19
MASON
LAKE
OSCEOLA
CLARE
62
GLADWIN
97
18
HURON
9
OCEANA
12
MECOSTA
ISABELLA
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MIDLAND
BAY
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141
MUSKEGON
NEWAYGO
MONTCALM
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TUSCOLA
SANILAC
GRATIOT
SAGINAW
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343
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GENESEE
LAPEER
ST. CLAIR
OTTAWA
KENT
IONIA
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BARRY
EATON
INGHAM
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OAKLAND
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118
485
2950
VAN BUREN
KALAMAZOO
CALHOUN
JACKSON
WASHTENAW
WAYNE
109
10
28
28
19
63
46
BERRIEN
CASS
ST JOSEPH
BRANCH
HILLSDALE
LENAWEE
MONROE

DIRECTORY OF MEMBERS

As of September 1, 1968

Active	6464
Life	600
Retired	170
Associate	416
Honorary	8
Non-Resident	3
Military	82
Total	7743

The figures on the map include the total number of members in each component society.

Open-eyed nights

Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

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Valium® (diazepam)

useful for the relief of psychic tension,
alone or with associated depressive symptoms

Whenever anxiety induces or intensifies clinical symptoms

Librium®

(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination, on proper dosage~ Has wide margin of safety

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs T.M. (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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1969-Detroit, September 28-October 3
1970-Detroit, September 20-25
1971-Grand Rapids, October 3-8

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